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ORTHOPEDIC SURGERY

ITS SCOPE AND ITS FUTURE *

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SAN FRANCISCO

The practice of medicine embraces all branches of the healing art, and has no natural boundaries within itself. No man or set of men can appropriate a portion of it, claim it as private property, and warn trespassers off. Medicine is like the surface of the earth; what belongs to one body of men to-day may belong to another to-morrow. The fit shall take what the unfit cannot hold. Constant change is the symbol of life, and distinguishes scientific from sectarian medicine.

Specialties spring up in answer to a demand for concentration, for no one man can cover the entire field. All knowledge that the student unearths becomes, not his property nor the property of those associated with him in a similar line of work, but the property of the entire medical profession.

So long as a specialty is contributing to the advancement of knowledge, it tends to hold its ground, and to advance its borders. When it stops, other specialties encroach on it. It must take up new ground to avoid absorption either piecemeal by other specialties, or bodily by general medicine and by general surgery. Such a change of ground we have witnessed recently in gynecology. Whether the gynecologists can maintain their new position remains to be seen. If they succeed to the field of abdominal surgery, they will succeed to it, not by claiming that they are entitled to it, but by demonstrating that they are best equipped to hold it. When in my childhood's happy days I would say to my esteemed parent that I was "entitled" to this or to that, he would answer: "My son, you are entitled to just what you can get."

Orthopedic surgery was born to a strenuous life, and has held its borders, never sharply defined, by constant struggle. Its right to the name of a specialty, as you know, is still disputed. It is not recognized generally in medical schools as worthy of a faculty chair, and in many large communities it is not represented exclusively. Its pioneers devoted themselves largely to perfection of mechanical devices, and to accumulation of clinical data, but this knowledge has been appropriated quite rightly by our confrères, who are capable of applying much of it reasonably well with the aid of a skilled mechanic. We have no exclusive title to it. It does not "belong" to us.

We cheerfully acknowledge the remarkable work of the early orthopedists, but we shall gain nothing by pointing back to it. Their deeds reflect no luster on us. To dwell on former greatness is a symptom of degeneracy.

No one can say what our future will be, but that we are in the midst of a change, not on the verge of one, is evident. See what even now is taking place within our ranks. Compare our programs with those of orthopedic meetings of twenty years ago. Work of most diverse kinds is laid before us, demanding recognition and giving an intimation of the modern conception of the scope of orthopedic surgery.

Some there are who maintain that what was good enough for our predecessors is good enough for us. While we may not agree with them unreservedly, it will be well not to neglect that line of endeavor which gave our specialty birth. We must remember, however, that this branch of our work is shrinking constantly. Pott's disease formerly "belonged" to us without question. Orthopedists devise operations for ankylosing the spine, and the general surgeon invades our field—a good example of the changing boundaries of medicine.

Many, imbued with the scientific spirit, and impatient of didactic statement, devote themselves to the task of proving what we are wont with great complacency to regard as established truth, and they maintain with some fervor that much of it is not only not established, but is not even true. We must listen to them, though their discoveries throw into the scrap-heap the theories gained by years of hard work. By animal experimentation and by laboratory investigation they will put our knowledge of the diseases of the body framework on a sound basis. Here surely lies part of the work of orthopedic surgery in the future.

The specialty must be stripped of every rag of the garment of mysticism which so persistently clings to it.

Diseases of bones and of joints furnish many of the baffling problems of modern medicine. They affect tissues whose histology, physiology and pathology are almost unopened books. We cannot understand disease in tissues of whose structure and function we are ignorant. Here is a work to fire the imagination of the young. A few years spent in patient investigation may bring more lasting renown than a lifetime of clinical observation.

We have been too ready to draw conclusions without sufficient foundation of fact. One of the great needs in orthopedic surgery is the accumulation of solid facts.

Some diseases of bones and joints are said to "belong" to the general surgeon, others to the internist, but the field is open to all, and is almost unplowed.

* Chairman's address, read before the Section on Orthopedic Surgery at the Sixty-Fifth Annual Session of the American Medical Association, Atlantic City, June, 1914.

A subject, until recently sadly neglected, now forces wide attention. I allude to fractures and dislocations. The general surgeon claims them. They are his if he can hold them. The orthopedist maintains that his mechanical training gives him greater skill in their management. He must demonstrate his skill. He has done so in some instances, notably in congenital dislocations and in certain fractures about the hip and shoulder. The vogue of open treatment of fractures may be interpreted as a reaction against the slipshod methods of the past. It will stimulate at least to more exact conservative treatment.

Functional disorders are becoming fewer in number as an organic base is found for many of them. Some orthopedists maintain that an error in mechanics of the body framework is responsible for certain of these diseases. Their views, while in many instances still largely theoretic, are worthy of a respectful hearing, but not, let me remind you, of acceptance until they are definitely proved. Let us beware the wiles of those brilliant men who urge us to cut loose from sound pathology and scientific proof, to follow them along the easy paths of attractive speculation. These paths lead to confusion.

In other instances an organic cause has been established. The orthopedic surgeon finds one for "idiopathic" sciatica and lumbago, and for intercostal neuralgia. Whose rights does he infringe thereby? Certainly not those of internist or neurologist.

Some regard orthopedic surgery as a narrow specialty. To me it appears potentially the broadest in medicine. These are but a few of the possible fields of activity. Orthopedic surgery is what we make it, and in brief includes everything that we can do better than others.

The future is in the hands of the younger men. Trained for scientific research as we never were, and starting where we finish, they shall climb the heights of knowledge which our feeble eyes see but dimly in the distance. Let us applaud bravely when they bring the structures which we have built up crashing about our ears. This is progress.

"Not as though I had already attained, either were already perfect; but I follow after——. I count not myself to have apprehended, but this one thing I do: Forgetting those things which are behind, and reaching forth unto those things which are before, I press toward the mark."

Lane Hospital.

Habit as a Pathological Factor.—The "bad habits" which are so characteristic of the various psychoneuroses may find their counterparts in perversions of the structural activities of the cells—that is, in bad habits of body (cachexias). Thus, for example, we find a tendency to the laying on of fat (lipomatosis, adiposis dolorosa, etc.)—i. e., to the formation of a tissue less highly organized than the normal—frequently associated with absence of the reproductive function (e. g., following the menopause, castration, etc.). The meaning of this is that function must go on somehow, and, in default of the "discontinuous growth" (reproduction) which normally succeeds ordinary "continuous" growth when maturity is reached, the individual, unless he has found some other active outlet for his energies, tends often, as the saying is, to "run to fat." Any one of the separate organs, also, which fails to express its normal capabilities is apt to begin to energize on a subnormal plane; witness fibromyomas in the non-functioning uterus. . . . A bodily habit, whether bad or good, is a group of cellular activities which have evolved together and grown into a complex which . . . is difficult to break up.—Arthur J. Brock, *Edinburgh Med. Jour.*

A PLEA FOR A MORE EXTENSIVE OPERATION IN CANCER OF THE BLADDER*

ARTHUR L. CHUTE, M.D.
BOSTON

After considering various subjects as possible topics for my address, I chose the one concerning which I really can give you fewest facts. I hope, however, that these few facts and the suggestions to which they give rise may arouse you to renew your attack on cancer of the bladder along lines that differ a little from those which we have in the main been following.

In my opinion there is no chapter in urinary surgery that is so absolutely discouraging as that which deals with our end-results—our so-called "cures" in cases of malignant disease of the bladder. I will grant you that our palliative treatment is very successful, that we make many of these sufferers very comfortable; but I feel that I am not ready to confess that we are reduced to nothing more than palliation in these cases.

If in any series of cases one mixes in a certain number of papillomatous cases—the large massive ones that have the appearance of a bladder tumor—one can get figures which are not absolutely discouraging. If, on the other hand, we deal with the carcinomatous growths that are primary in the bladder—squamous celled cancers, adenocarcinomas and the mucous cancers of the bladder, the growths which infiltrate and lead to metastases—our ultimate cures are almost none.

In the past few years we have increased very much the extent of our resections for malignant disease of the bladder and we have also made transplantation of the ureters relatively common, carrying out this maneuver whenever there was a reasonable question of the ureters coming into the diseased area. In spite of these more sweeping operations, I believe there is a very definite doubt whether our end-results are any better. Mine I am sure are not. I very much doubt if the number of permanent cures is at all proportionate to the increased immediate mortality of this more extensive operation.

This whole subject has come to me with particular force of late, as I have been studying up my cases of infiltrating bladder growths. I find records of twenty-nine cases, in eighteen of which operation was performed. Of these eighteen patients operated on, there was only one who was without signs of recurrence at the end of three years after operation. I am unable at the present moment to report on this patient's condition as I am not able to get into communication with him; but so far as I know he continues free from symptoms. There is another patient who has been operated on relatively recently, and I do not know that he has a recurrence; in fact, I believe he has not. All the others are either dead or have definite recurrences. I believe and hope that these figures are worse than the average, but fear they do not exaggerate the condition much.

It is wholly unnecessary, before this Section, to emphasize the importance of early diagnosis of cancer of the bladder, what its first symptoms are, and what its cystoscopic appearance is. Neither shall I deal with the technic of operation, but shall devote my time

* Chairman's address, read before the Section on Genito-Urinary Diseases at the Sixty-Fifth Annual Session of the American Medical Association, Atlantic City, N. J., June, 1914.

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to a consideration of what I believe are certain basic principles in its treatment.

In the study of my cases there came out certain facts, more or less disconnected, but that have, I think, a definite bearing on the question of the treatment of cancer of the bladder. In the first place, the one patient who has fulfilled the minimum arbitrary requirement that allows one to speak of cure in connection with cancer treated surgically—that is, the expiration of three years without signs of recurrence—was one of the patients whose operation was least extensive, though it was carried out about a month after the appearance of his first symptom, hematuria—the earliest case that has come under my care. This patient presented cystoscopically simply a little granular-looking area that was fairly widely removed laterally; it was not, however, very deeply removed. The incision went into the muscular layer only, not through it. Another important fact came out in the study of the condition found at the necropsy on one of my patients, who, a year before, had had a mucous cancer removed from the vertex of his bladder. This growth, including the full thickness of the bladder wall, was removed with a wide margin by the transperitoneal method. Though at operation I had been unable to find glands, at necropsy there were huge masses of retroperitoneal glands that were cancerous. More recently, I have chanced to notice in three other patients, on whom I did palliative operations, that the glands within the abdomen were involved.

It seems to me impossible to overestimate the importance of these two observations, illustrating (as I believe they do) fundamental points in the treatment of cancer of the bladder. The first, if I interpret it rightly, illustrates the fact that when a bladder growth is actually limited to the mucosa, we may excise it and have reasonable hope that there will be no recurrence. This depends on the generally accepted belief, which I believe is perfectly reasonable when we consider the storage function of the bladder, that its mucosa is either entirely without lymphatics or very poorly supplied with them, and that while a growth is actually confined to this layer there is nothing in the way of metastasis possible, the only extension being by continuity. The simple removal of a growth at this time destroys it *in toto*.

This accounts for what has been observed from time to time; namely, that freedom from recurrence has by no means been confined to the cases that have had wide removal of their growth; that it has appeared from time to time in patients whose growth has been excised with a very small area of healthy tissue. I believe that I am right in saying that in some of these cases, as in my own case, the microscopic examination left no doubt that the growth was really carcinoma.

Regarding the second point that I believe of importance—the finding of masses of carcinomatous abdominal glands at necropsy, and in three instances, of lesser glands at the time of operation—I believe that this illustrates at least one important route, probably *the* important route, by which these growths become disseminated. Though I felt no glands at the time I resected this man's bladder they may have been there at that time. Whether they were or not, I believe that this question of the lymphatics, both vessels and glands, is a most important one in the treatment of cancer of the bladder, one from which we may reasonably look for help.

In operations for cancer of the breast, tongue and stomach, and in the more modern methods of extirpation of the uterus and rectum, the lymphatic system is taken into very definite consideration and an attempt is made to remove diseased lymphatics and glands, with, so far as one can judge, improved results as regards cures. So important is this that it seems justifiable to increase the operative risk greatly in order to accomplish it. In cancer of the bladder, although we have had most disappointing results with present methods, we have simply widened our areas of resected bladder, still absolutely ignoring the possible part played by the lymphatics.

I think this is rather remarkable when we consider how essential a part of the plan of the modern surgical attack on malignant disease in other situations the tracing out of the course of the lymph-vessels has proved, and how carefully the removal of the diseased focus has been followed by the removal of the lymphatics and glands. I think at once of two possible reasons why this has not been done in cases of cancer of the bladder. One is the tradition that metastasis comes only late in these cases and that a dissection of the pelvic lymphatics would, therefore, be unnecessary. The other is that the operation would be so severe as to be impracticable in patients over 50—the age at which we see most cases of cancer of the bladder.

I am not ready to concede that this is necessarily so. I feel, however, that we should give this subject careful, attentive study in the hope that we may materially increase the number of patients who remain well following the removal of a cancer of the bladder. I am convinced that the most of our operating in this field is what one might fairly call "puttering"; we busy ourselves with little things and avoid great essentials. I feel that the removal of the lymphatics will be followed by better ultimate results than we now get.

Before an operation of this sort can be standardized it will be necessary to gain a wider knowledge of the lymphatics of the bladder than is generally possessed at present—whether or not different regions drain uniformly by the same channels. It will be necessary to find what cases it is useless to submit to so extensive a procedure. When this has been done, I believe that it will be found that a careful removal of the pelvic lymphatics will diminish the number of recurrences, much as seems to have taken place in the Wertheim operation for cancer of the uterus.

There is still another point that has a definite bearing on our method of operation. This is the fact that in ten out of twenty-nine cases the bladder growth had its seat so close to the bladder outlet as to make its local removal impossible without destroying the bladder outlet, in which case its total removal with the transplantation of the trigon and ureters would seem the rational procedure. I have always felt that total cystectomy was too fearful a mutilation to be often advised; yet if my series of cases is an average one, we must evidently advise it in one case in three if we are to remove the primary growth adequately—the first essential for successful treatment in all malignant disease. If in these cases the lymphatic current is found to be such that we can preserve that part of the trigon with the ureter openings and transplant it successfully into some part of the intestinal tract, preferably a part that has been shut off from the rest, to act as a new urinary bladder—if we can do this, the horror of total cystectomy will be materially lessened. Surgically there can be no question of the excellence

of Watson's double lumbar nephrostomy as a preliminary to total cystectomy; personally, I feel I should not wish it. However, I think that unpleasant as total cystectomy is, we must expect to carry it out relatively frequently or else, because of inadequate removal of the local focus of disease, give up all hope of cure in a considerable proportion of cases of cancer of the bladder.

My contentions are that with every effort to recognize malignant disease of the bladder early, it will nevertheless be impossible to operate on more than an occasional patient when the disease is confined locally; in order to hope for better results in our treatment of cancer of the bladder, we must include as an essential part of our operation a dissection of the lymphatics of the pelvis; this must be done by routine, much as a dissection of the axilla is made in all breast cases except a few that are clearly too advanced to make this of advantage. When the local removal of the diseased area necessitates cystectomy, it must be carried out, or it is perfectly evident before we begin our operation that we shall fail in our object, that of stamping out the disease.

350 Marlboro Street.

SUBTOTAL CYSTECTOMY *

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Cancer of the bladder constitutes 3 per cent. of all cancers in the male. Up to comparatively recent times we have had no adequate surgical technic for extirpation of malignancy in this organ. This is due to a number of factors, most important of which are: (1) the difficulty of conservation of the terminal ureters; (2) the lack of a definite surgical anatomy; (3) the questionable reparative power of the bladder, and (4) the hesitancy to attack the problem along definite surgical lines. An ideal extirpative operation for vesical neoplasm will be a technic which conserves or reconstructs the three natural orifices of the bladder, and one that removes the tumor *en masse*, with ileac adenectomy when the glands are involved.

In a consideration of this ideal operation there are certain facts to be thought of. It has been observed by a number of men and repeatedly demonstrated to me that if the three orifices of the bladder are conserved the bladder will regenerate and provide a functionating urinary receptacle. Another consideration is the desirability of a wide free exposure of the entire posterior surface of the bladder and base. Such a procedure may be accomplished either by transperitoneal dissection or as an entire extraperitoneal technic. In my earlier cases I regularly used a transperitoneal method but of late have carried out the technic entirely extraperitoneally. Where possible the anterior or pubovesical attachments are left intact. To meet the operative requirements both ureters must be constantly in sight; the lateral ileac extraperitoneal spaces readily available for exploration, and the entire bladder except the anterior portion freely mobilized. I believe that benign papilloma are at the present writing best treated by Oudin current. I believe that if any operative procedure is to be carried out for a vesical neoplasm, that neoplasm must be considered as actively or potentialiy malignant, and any operation for its removal must not be a simple excision but must be radical, along definite anatomic lines—in short, a *subtotal* cystectomy.

TECHNIC OF SUBTOTAL CYSTECTOMY

Description.—An operation for removal of a part or all of the bladder. Generally speaking, most operations involving the removal of a portion of the bladder are considered under the head of cystectomy, complete removal of the bladder being more in the nature of an operative curiosity than a feasible surgical procedure. The operative procedures may be carried out intraperitoneally or transperitoneally or as a straight extraperitoneal operation. It has been repeatedly observed that the bladder possesses wonderful reparative powers, and it has been demonstrated that from two-thirds to three-fourths of the bladder may be removed with subsequent adaptation to form an efficient urinary receptacle.

Incision.—This may be transverse or a median longitudinal incision (cystotomy). The longitudinal incision begins 1 inch above the navel on the left side and extends downward to the symphysis.

Step 1: The anterior sheath of the rectus muscle is divided about 1 cm. to the left of the mid-line and the left rectus displaced outward. The posterior sheath, above the semilunar fold of Douglas, is divided and the peritoneal fat exposed from the navel to the symphysis. By gently swabbing the fat and loose connective tissue up toward the navel, three important structures or surgical landmarks are brought into view. In the median line is found the urachus extending from the navel to the vesical apex. From the navel to each side of the urachus are found the obliterated hypogastric arteries, represented as divergent fibrous cords. These structures having been located, two procedures are in order: either to open the peritoneal cavity and continue the operation as a transperitoneal procedure, or to carry out the operation entirely as an extraperitoneal incision.

Step 2: The peritoneum is incised from the navel down to a point corresponding to the semilunar fold of Douglas. The patient is placed in an extreme Trendelenburg position and intestines gently deposited in the upper portion of the abdominal cavity. The pelvic cavity is thoroughly walled off by one or two long continuous rolls of sterile gauze. Two laparotomy pads are attached at each end of the wound in order to protect the incision from implantation of tumor cells.

Step 3: The urachus is grasped at the lower angle of the peritoneal incision by a Barret intestinal forceps. Traction is made upward, throwing into relief the obliterated hypogastric arteries as they divaricate to enter the true pelvis. The left obliterated hypogastric artery is grasped with forceps and traction made upward and to the right. By blunt dissection between the obliterated hypogastric artery and lateral wall of the pelvis, the left vas deferens is brought into view as it courses along the pelvic wall to the inner side of the obliterated hypogastric artery.

Step 4: A blunt single hook retractor is passed under the left vas deferens and gentle traction exerted. Blunt dissection is continued downward along the course of the vas deferens, and the pelvic ureter is uncovered as it bends inward above the fascia of the pelvic floor to enter the bladder, the ureter at this

* Read before the Section on Genito-Urinary Diseases at the Sixty-Fifth Annual Session of the American Medical Association, Atlantic City, N. J., June, 1914.

point being crossed on its inner side by the vas deferens. A similar exposure is made on the opposite side and the right ureter exposed. Any radical procedure directed to the extirpation of neoplasm of the bladder must have the two ureters exposed and constantly in view. This is the essential point in any radical technic.

Step 5: The urachus is divided close to the summit of the bladder and traction is made on the bladder downward toward the symphysis. From the two points of lateral dissection previously made the peritoneum is stripped off the fundal surface of the bladder. The denudation extends deep into the rectovesical space and the peritoneal culdesac of Douglas is pushed upward and backward. If the peritoneum is found firmly attached to the bladder and already the seat of malignant infiltration, this area is left undisturbed and a wide encircling incision made about the infiltrated peritoneum. If the peritoneum is not infiltrated, the entire bladder, except the anterior or pubovesical attachment should be freely mobilized, both ureters free, and the superior poles of the vesical and the upper portion of the posterior surface of the trigone in sight. The entire procedure can be carried out without entering the peritoneal cavity. Occasionally, the peritoneum is torn into and should be brought together with No. 1 plain catgut. No hemorrhage of any moment should have been encountered and the venous ooze should have been readily controlled by hot wet pads.

Step 6: The denuded lamella of peritoneum is carefully attached to the upper end of the abdominal incision, so that, for all further operative procedures, the peritoneal cavity is to all intents and purpose closed.

Step 7: The bladder is grasped high up on the posterior surface and an incision is made in the longitudinal direction, about 1 inch in length. Through this opening an inspection of the bladder is made and the topography of the tumor determined. The incision is extended in any direction that may be necessary for proper operative exposure. Since, in the majority of instances, the tumor will be found to occupy the summit, side or trigone of the bladder, an incision downward in the posterior median line, which splits the organ in half will be the usual incision of election.

Step 8: The neoplasm is excised *en masse*, together with a wide margin of healthy, uninvaded tissue comprising the entire thickness of the bladder wall. The exposure of the ureter, which has already been made, now becomes of prime importance. If the ureter is affected it is divided between the ligature above the growth and the distal portion is removed with the tumor. The proximal portion is allowed to remain undisturbed until partial closure of the bladder defect is accomplished.

Step 9: The hiatus of the bladder wall after excision of the tumor is partially repaired (the method of closure being similar to the Connell intestinal suture with No. 2 chromic gut), a stab-wound is made through the bladder wall at a point approximating the normal ureteral opening and the proximal portion of the divided ureter drawn through this opening by a thin dressing forceps.

Step 10: The ureter is brought through the stab-wound and anchored to the bladder wall. About ½ or ¾ inch of the ureter is allowed to protrude into the bladder. Two flaps are made by dissection of the ureteral stump and the flaps turned back and anchored *in situ*. The remaining defect in the bladder is closed with a Connell suture as above and drainage of the bladder instituted by means of a stab, button-hole incision, anterior to the line of incision and at a point that will correspond to the highest point of the bladder when the operation is completed. Through this aperture a No. 26 F. soft rubber catheter is drawn and sutured *in situ*. A drainage-tube inserted in this manner insures against leakage along the tube into the perivesical space.

Step 11: The final step is the reposition of the peritoneum over the vesical suture line and an accurate closure of the peritoneum. If the peritoneum is invaded by the growth, the involved portion is resected with the growth and the peritoneal hiatus closed after the usual fashion, particular care being taken to prevent a peritoneal suture line being superimposed on a bladder suture line. A cigarette drain is inserted into each lateral space leading down to the ureter and the abdomen closed with Figure 8 silkworm sutures. In addition, a self-retention catheter is inserted.

COMMENTS

The operative treatment of tumors of the bladder has been inadequate in preventing local recurrence and implantation metastases. In a case of malignant tumor, the tumor *per se* should not be handled and the excision must be through all the coats of the bladder and the peritoneum adjacent to the bladder wall if found to be infiltrated. The wide denudation in the preceding technic can be made with the patient in a high Trendelenburg position, either intraperitoneally or extraperitoneally.

The vas deferens in the male offers the most reliable and quickest way of reaching the terminal ureter. The blunt dissection along the lateral walls of the pelvis allows for the exploration about the ileac vessel for metastatic glands.

In the female the relation to the uterine artery allows for an accurate localization of the terminal ureter.

Any cystectomy for vesical tumor should be radical along the lines indicated above. In substance there is no difference between intraperitoneal and extraperitoneal surgery for this class of work. Leakage, if it does occur, does not take place into the peritoneal cavity when the peritoneum has been sutured carefully with a serous approximation of surfaces. If after opening the bladder a malignant neoplasm is excavated or sessile, cauterization of the base or surface of the tumor is a procedure of undoubted palliative value. After excision, searing the cut edges before suturing is a very wise precaution. The use of 50 per cent. resorcin or 1:5,000 mercuric chlorid, swabbed about the bladder, is useful in destroying any detached tumor particles.

49 East Forty-Ninth Street.

ABSTRACT OF DISCUSSION

ON PAPERS OF DRS. CHUTE AND SQUIER

DR. EUGENE FULLER, New York: Cancer of the bladder has, as a rule, been treated in a very haphazard and unsatisfactory manner. Such work as Dr. Squier has shown is certainly beautiful. It gets down where the disease is in the cases that are so operable, and leaves practically nothing to chance. We have been inclined in most cases to rely on sparking and to sit back and do nothing else, which is a bad thing, although in certain cases the spark has done good and is the approved treatment. It is only in certain cases, how-

ever. I had one case in which I operated for cancer of the floor of the bladder, and the man was living ten years afterward. In that case I resected a large portion of the bladder. I made a suprapubic incision, transfixed the whole mass, took it out, and got a perfect result. Operating like that is more or less haphazard. Five years afterward I operated in this same case for a little recurrence in the stump, and took that out. It is advisable in these cases to operate radically. Again, there may be a case in which one thinks one has done radical work and is disappointed. Not long ago I had such a case in which I resected a considerable portion of the bladder. The man, I thought, was doing extremely well; he got up; but five weeks after the operation he had a spontaneous fracture of the upper thigh from metastasis. I do not think we could manage radically cases like that which Dr. Squier reported, except by the careful method which he described.

Dr. John L. Atlee, Lancaster, Pa.: I report two cases with a great deal of reluctance. I had, recently, two cases of cancer of the bladder in which I did a total extirpation. The first one I did simply because I did not know what else to do. The man had a cancer in the location shown by Dr. Squier, I would say, possibly half again as large. In the cases that I had seen in which no attempt had been made to relieve, the patients had suffered so that I felt I was justified in making the attempt. In that case I did a total extirpation, simply skinning the bladder from the prostate. The ureters were stitched together where they crossed the rectum and were transplanted together like the barrels of a double-barreled gun. The abdomen was drained, and a large rubber tube placed in the rectum. That man is 52 years old. There was very little shock. His recovery was very satisfactory. The control of his rectum was very satisfactory. He also had satisfactory sexual intercourse. He lived nine months and died from recurrence. He had pain in the region of the kidney, which I thought was due to an ascending infection, but at necropsy the glands were involved all over that side, and I felt that the pain was more due to the glands than to an ascending infection. Both ureters were full of turbid urine, and there was no evidence that I could see of an ascending nephritis. The second patient was operated on about two months later, about eight months ago. The man was 63 years old. The operation was done the same way, except that the ureters were cut higher up, and the left ureter was stitched into the sigmoid. That man is still alive, although he does not look well. He had one attack of ascending infection on the left side, with pain and rise of temperature, but he recovered. He was feeling well when I saw him three weeks ago, but he does not impress one as being a healthy man.

As I said, I did these operations with, possibly, no justification except to try to save the patients from a terrible death. If the lymphatic drainage of the bladder is as free as some authorities claim, that is, not only into the pelvic glands, but also into the inguinal glands and into the saphenous glands, a block dissection of the bladder is impossible. Therefore, if a block dissection is necessary it would be impossible in the bladder, because it is difficult enough in the Wertheim operation. If we applied it as a palliative operation the chance is that the patient would die as soon from infection as he would have died from metastasis. I was surprised at the comfort these men had in passing the urine from the rectum. They would go all night without urinating. One of the men was strong enough to go back to work, but did not have to do so. Both men expressed themselves as perfectly satisfied with that method of voiding urine.

Dr. Francis R. Hagner, Washington: The point Dr. Squier makes about getting at the ureter first and separating the bladder afterward, simplifies the operation very much. I have not done this operation by his method, but I have taken calculi out of the ureter by the same method. It is possible to get a better exposure than in any other way I know of. Dr. Chute has spoken of infection of the glands in these patients. Any one operating on such a patient and seeing large glands would remove them. It is a question whether it would do any good. We know the glands are not involved until late in the disease, and I have seen necropsies on such patients in which there was no involvement of the glands. Some years ago I presented a method of operating on growths of the fundus and lateral walls of the bladder by cystoscoping the patient, and under visual inspection outlining the growth with traction sutures. One of the weak points in the removal of growths from the bladder is the traumatism to the growth, and by this method it is easy to remove them without traumatism. One patient was operated on four years ago and has had no recurrence; one over three years ago, with no recurrence, and another died recently from some intercurrent trouble with no evidence of recurrence.

Dr. R. L. Rigdon, San Francisco: What would Drs. Squier and Chute do in such an instance as this? Just before leaving home I examined a patient who presented a well-defined, rather small tumor, occupying the right side of the bladder, including the bladder neck, apparently taking in the urethral orifice. Let us take it for granted that from a general point of view that man is suitable to be operated on. Whether or not the ureter is involved does not seem to make much difference because we can transplant that; but when I go back home what shall I do for that man? If I operate on him I must remove the sphincter of the bladder, at least a portion of it. I was in hopes that some of our members would report a brilliant series of cases treated by means of the spark so that I might be saved the necessity of doing a more radical operation on that patient.

Dr. B. A. Thomas, Philadelphia: The rationale of the extraperitoneal and the transperitoneal route of approach in these cases with the partial excision of the bladder described by Dr. Squier is certainly the most valuable suggestion which has yet been offered in cases of cancer. I strongly believe that the method *par excellence* for treatment of papillomas of the bladder, whether single or multiple, is the method of high-frequency desiccation or sparking by the Oudin high-frequency current, and I have treated no less than thirty tumors in this manner, with very excellent results. How does Dr. Squier distinguish between carcinoma and papilloma? I think the impression that he desires to make is that this operative method is applied only in undoubted cancer of the bladder, but I would enjoin the importance of this differentiation, in view of the superior advantage of the electric-spark treatment in cases of papillomas. We all know that in papillomas there may be two sites at which epithelial degeneration and cancerous formation take place; these are, superficially and at the pedicle attachment with the bladder-wall. Even though the surface of the growth is cancerous, the pedicle may not be, and one can cure such epithelial superficially degenerated tumors, if one is able to make the differentiation, by the high-frequency spark. On the other hand, if there be cancerous degeneration of the pedicle, the only method of treatment is that which has been described by Dr. Squier.

Dr. Louis E. Schmidt, Chicago: I am in accord with Dr. Squier's statement that one should start out intelligently. In other words, the diagnosis must be accurate as to the location and extent. If a tumor is located on the left side of the bladder it would be rather unnecessary so far as his procedure is concerned, to separate the right side of the bladder completely, because, with a thorough understanding as to the location, the parts can be separated as was shown. I am in the habit of avoiding the intraperitoneal operation. If the tumor is located low down, not involving the ureter, I do not do the so-called Watson or intraperitoneal operation. I separate the peritoneum sufficiently far from the tumor, and if I see that the peritoneum is adherent it is then opened up sufficiently distant and can then be closed before the tumor is excised. One of the mistakes frequently made—at least I have seen it and have made it myself—is to distend the bladder to such an extent that the bladder-wall is of paper thinness. By so doing you easily rupture the bladder when stripping off the peritoneum. I prefer not to distend the

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bladder to any extent, and the procedure can be carried out as Dr. Squier has described it. I do not believe that the extent of bladder tumors plays such an important part in the prognosis, although we have always been told that the larger the tumor the greater the possibility of metastasis, particularly glandular. I operated nine years ago for a spindle-celled sarcoma, which is fairly malignant I think we will agree, when the entire bladder except the trigon was removed. This individual now has a bladder which is absolutely not to be recognized from any other bladder. He can hold his urine from eight to twelve hours, and has absolutely no vesical symptoms. In the past two months I have operated on him for an inguinal hernia. In this person there was certainly no glandular involvement. I have cases of resection of the bladder for cancer in which operation was done seven years ago with transplantation of the ureter. I have several cases in which resection of the bladder was done four or five years ago when a part of the trigon was removed, with a fair-sized portion of the posterior wall of the bladder. If, in those instances, there had been any marked metastasis in the glands, four or five years is a fairly long time, though it does not absolutely exclude the possibility that these individuals may die of cancer. In the last six months I have made three extensive operations for cancer, and the patients are still living. In opening the abdomen, however, it is well worth while always to examine for glandular enlargement. I believe that if enlarged glands are found it is almost a hopeless proposition. So far as resection of the neck of the bladder is concerned, I think many patients who have been operated on will be relegated to a different field of therapy.

DR. GRANVILLE MACGOWAN, Los Angeles: The character of most of these tumors can be fairly differentiated by the careful use of the cystoscope. I do not use the high-frequency current for sparking a tumor that looks at all suspicious. If it is frankly a papilloma, it can usually be destroyed by the high-frequency current unless situated just above the bladder neck where they are difficult to get at. If a tumor is sessile or manifestly indurated, I consider it a cancer and regard as foolish the application to it of any mode of electricity or cautery except through a suprapubic incision. One must remove more of the bladder than just enough to get whatever is manifestly cancerous. I deprecate the use of the knife or scissors. There are electric cautery points made from iridoplatinum that are extremely efficient, easy to manipulate and allowing rapid work. After the removal of the tumor, any bleeding vessels should be ligated. I have had extremely satisfactory results with resection by the electric cautery, when not more than one-half of the bladder surface was included in the growth. I operated on one woman in 1900 for a cancer by this method, who was well until 1905 when another cancer appeared in an entirely different portion of the bladder. This was removed in the same way and she was well until 1911 but died in 1913 of cancer of the bladder. From 1906 I used the cystoscope on this patient two or three times a year and she had no cancer until 1911. With regard to Dr. Rigdon's case, if the cancer is situated on the vesical neck and it is hopeless to attempt to excise it without taking away the neck, I would not be deterred by regard for the internal sphincter, because I have removed bladder necks in operations for cancer of the prostate, with after results showing that the internal sphincter is negligable with reference to the retention of urine. In such a case the most reasonable thing to do is to side-track the bladder. If the bladder were removed as a receptacle for the urine by such an operation as was done by Dr. Atlee, I think it would solve the problem. I object to the use of the knife in cancer, because if a metastasis has not already taken place, it is easy to cause one by squeezing some of the cancer-cells into the open blood-vessels or the lymph-channels. The cautery seals up both blood-vessels and lymph-spaces. The cautery provides against the carelessness of one's assistant and of one's self. The cautery will cut, if you have the right kind.

DR. WILLIAM E. LOWER, Cleveland: This is one of the most important unsolved problems that we have in genito-urinary surgery. Many of the operations on other parts of the genito-urinary tract are being more or less standardized, but this is an extremely annoying one, at least it is to me, and as Dr. Chute has stated, it is an operation that one does not expect very much from, but sometimes the results are surprising, showing a resistance to a particular kind of growth perhaps, rather than to any particular kind of operation. I think we make one mistake in these cases in not requiring our patients to come back for inspection as often as they should; after operation for cancer of the breast the surgeon asks his patient to report every three months. We wait until they have symptoms. If the patients come back every three months as I am having them do now, and we use a cystoscope, we can discover a recurrence, if any appears, fairly early, and at a time when remedial measures may be used, but if we wait for such objective symptoms as hemorrhage, etc., it may be too late. I recall one case that I reported before, in which I removed the tumor suprapubically by excision, and in less than four months it recurred. By the judicious application of the spark I have been able to keep the patient perfectly well now over three years. It was not a radical operation. In another case in which we did a radical operation we found that metastasis had already occurred and the patient was dying from metastasis in the bones. I am hopeful that this problem will be worked out in some way, because, as it is now, it is most discouraging and most unsatisfactory to be obliged to give the present results of operation for malignant tumors of the bladder to a patient presenting himself with such a lesion.

DR. MARTIN KROTOSZYNER, San Francisco: The rapidity with which malignant bladder growths will occasionally recur and increase in size was made manifest to me recently in the case of a woman of 41 in whom a portion of the bladder had been resected for carcinoma. A few months afer this operation a careful cystoscopic examination revealed a normal bladder, but about two months later a large mass was seen to occupy the whole left side of the viscus. Since the patient refused any operative interference, I proceeded to fulgurate the neoplasm and the rapidity of the onslaught of the malignant infiltration became manifest through the fact that from one week's sitting to the next, new growth of carcinomatous tissue became visible within the fulgurated area. This case was to me another proof of the futility of treating malignant bladder-growths with the spark.

DR. J. BENTLEY SQUIER, New York: With regard to the differential diagnosis referred to by Dr. Thomas, I simply state that the majority of vesical tumors are potentially malignant, if not clinically so, at the time we see them. I believe that one should not spend too much time in experimenting with the high-frequency current on any tumor unless there are unmistakable signs of improvement at once. Otherwise, get busy and operate. I think we will all agree with that. I have never had the opportunity to try Dr. Hagner's operation. It would strike me as being the ideal radical operation on a cancer, if one could outline the extent of the tumor beyond any question of doubt before extirpation is attempted, and I would recommend it as a wonderful operation for carcinoma situated in the vertex of the bladder. Dr. Schmidt asserts that one should make a correct diagnosis of the extent of the tumor by the cystoscope. I do not believe one can make an absolutely accurate diagnosis as to the extent of a vesical tumor by means of a cystoscope.

DR. SCHMIDT: I said as nearly as possible. I said the location, not the extent, because I do not believe we can look through the bladder wall.

DR. SQUIER: He says he should not open both lateral perivesical spaces because if the tumor is situated on one side one can locate it without so doing.

DR. SCHMIDT: I mean that when the tumor is on one side of the bladder it is not necessary to peel the entire bladder out. One can feel the extent of the tumor. I think anybody who has done any surgery of the bladder will agree with me.

DR. SQUIER: Dr. Schmidt is correct. I think that by the use of the cystoscope one cannot tell how much of the bladder-wall is involved in carcinoma. Therefore I believe that a general mobilization of the bladder gives one a greater

ability to handle it correctly, Dr. Schmidt's criticism to the contrary notwithstanding. With regard to Dr. MacGowan's statement that he would not operate on these cases until they are ready to go to the grave—

Dr. MacGowan: I didn't say that. I said unless I could circumscribe the growth I did not care to operate.

Dr. Squier: My criticism of your remark would be the same. I defy you to outline it through the cystoscope.

Dr. MacGowan: I did not mean through the cystoscope.

Dr. Squier: What other criterion have you?

Dr. MacGowan: That was with reference to high frequency and the differentiation of a tumor that was manifestly a papilloma and one suspiciously a cancer. I would use high frequency on all those that clearly appear to be papillomas, and on account of the superficial action of the high-frequency spark I would not tease anything that looked as if it might be a cancer. I would either leave them alone if too extensive or if there were too large a number of them, or operate on them by the galvanocautery.

Dr. Squier: I am glad Dr. MacGowan has made his meaning clear. With regard to the knife or cautery, one is not cutting the cancer with the knife. Therefore, what is the objection to it? One is cutting the healthy bladder wall. Dr. Lower really voiced what I had in mind. It was not to describe any operation for carcinoma of the bladder which I thought would work in every case. I know in how many of my own cases it will not work, because I have tried it and I know exactly the results it will produce. I merely offered it so that some of us would go home and evolve a technic which would do something. We have sat back long enough and opened bladders and sent the patients home and have not given the patient a chance for his life. He is worse off than before. We have stimulated the cancer and given the patient a suprapubic fistula in many cases, and instead of being only unfortunate we have made him a nuisance to the community by making him smell of urine all the time. Let us do something definite or not do anything. The only criticism I would have is this, that if one is going to do a considerable resection of the bladder and depend on the line of sutures to prevent leakage into the perivesical space and possibly into the peritoneal cavity, the chance of primary union would be infinitely better following the use of the knife than the use of the cautery.

Dr. MacGowan: One can freshen the edges afterward and then put in the sutures and it will result in perfect union.

Dr. Squier: I do not question whether it is possible, but whether it would happen often enough to make it desirable.

Dr. A. L. Chute, Boston: There is little to be said concerning Dr. Rigdon's case. If you are going to give the patient a chance to be permanently well, all the malignant disease locally must be removed, including, in this instance, the bladder outlet. I see nothing to do but to perform a cystectomy, treating the ureters as seems best.

Surplus Energy and Progressive Evolution.—It appears to me that this power of profiting by experience lies at the root of our problem, and that in it we find a chief cause of progressive evolution. Jennings speaks of the principle involved here as the "Law of the readier resolution of physiological states after repetition," and, similarly, I think we must recognize a law of the accumulation of surplus energy as resulting therefrom. Let us look at the case of the accumulation of food-yolk by the egg-cell a little more closely from this point of view. Every cell takes in a certain amount of potential energy in the form of food for its own use. If it leads an active life, either as an independent organism or as a constituent part of an organism, it may expend by far the greater part, possibly even the whole, of that energy upon its own requirements, but usually something is left over to be handed down to its immediate descendents. If, on the other hand, the cell exhibits very little activity and expends very little energy, while placed in an environment in which food is abundant, it will tend to accumulate surplus energy in excess of its own needs.—Arthur Dendy, *Medical Journal of Australia.*

CERTAIN MINUTE CYSTS OF THE METACARPAL BONES FOLLOWING TRAUMA, AND THEIR CLINICAL RECOGNITION.

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While cysts of the long bones are not infrequently encountered, yet those involving the short bones of the extremities have received little or no attention. I have recently met two examples of pea-sized cysts situated, respectively, in the head and the base of a metacarpal. Both of these immediately followed trauma (contusion of bone); by reason of persistent pain and "wincing" tenderness both would have passed for subperiosteal fracture, although there was no swelling or ecchymosis; there was no enlargement of the bone, and there were no signs of inflammation. It was only by close scrutiny of the roentgenograms that the faint outline of each cyst was detected. Operation gave immediate and complete relief in both cases.

Case 1.—Miss M. J., aged 61, cook, reported at the Surgical Outpatient Department of the University Hospital (Case Record 40013) March 11, 1914, with the history of an injury, incurred sixteen months previously, to the base of the first metacarpal bone of the right hand. Since then there has been pain, which has gradually increased in severity. Clinically, there was localized tenderness similar to that elicited in fracture, but not quite so severe or "wincing." There were no other signs of inflammation. A roentgenogram revealed a cavity the size of a pea at the ulnar corner of the base of the first metacarpal bone. Under nitrous oxid anesthesia an incision was made along the ulnar border of the base of the metacarpal bone. The tendon of the extensor pollicis longus and the carpometacarpal joint, which were hard by, being carefully avoided, the cavity was readily entered with a narrow chisel, and was curetted. It was packed with iodoform gauze, and a dressing and a splint were applied. On her return the next day the patient stated that she had been free from the boring pain for the first time in sixteen months. On discharge, two weeks later, the wound was all but healed.

Case 2.—Mr. J. W., aged 33, machinist, reported at the Surgical Outpatient Department of the University Hospital (Case Record 40893) June 18, 1914, with the history of an injury, inflicted five weeks previously, to the head of the third metacarpal bone of the right hand, which had been struck a severe blow against a metal oil-guard. Pain started at the time of the injury, and has persisted. It shoots down to the finger-tips. It is worse when he grips; there is none at night. Clinical examination revealed limitation of motion at the third metacarpophalangeal joint, and "wincing" tenderness at the head of the metacarpal. A roentgenogram revealed no fracture, but on close scrutiny a pea-sized cyst at the radial side of the head of the metacarpal and anteriorly.

Under nitrous oxid anesthesia and Esmarch anemia, an incision was made just to the radial side of the extensor tendon of the middle finger, and the bone was exposed by retracting the capsular ligament. The bone was removed from the proximal and radial portion of the head until the cyst was emptied. It was pea-sized and filled with clear, tenacious mucoid material. The cyst wall was curetted, phenolized and packed with iodoform gauze. The edges of the deep fascia were approximated. Hemostasis was secured and skin edges were approximated. A splint was applied. After the operation the patient stated that immediate relief from the shooting pain was afforded.

A roentgenogram, taken when the wound was entirely healed, shows the remains of the cyst cavity outlined by

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iodoform powder, which was inserted into it at a dressing a few days after operation. The cavity is much diminished in size.

A review of recent literature reveals but one case that may be compared with mine. McDill[1] reports a cyst in the distal half of the fifth metacarpal bone. It began three years previously as a small, painless swelling which gradually increased for a year, when it swelled rapidly, became painful, and was opened, giving exit to stringy mucopus, and discharged at intervals for the remaining two years. The roentgenogram shows an oval cyst with one end at the neck of the bone and the other just below the middle of the shaft, of which it occupies two-thirds of the width and one-fifth of the length. The shaft is not expanded. McDill says: "So far no case has been reported in the long bones of the hands or feet." Silver,[2] in a series of ninety-seven cases of bone cysts, found but one each in a metacarpal and metatarsal bone. Elmslie,[3] in an extensive review of the subject, says: "Most of the cysts of the metacarpal and metatarsal bones and of the phalanges have been definitely myxomatous, resulting from degeneration in enchondromata."

Robert Jones[4] describes three large cysts in the bones of the hand: expansion was present in all. Indeed, perusal of the literature of bone cysts shows that enlargement was almost invariably present. The cysts, colossal in comparison with mine, with the single exception of McDill's case, represent, without doubt, advanced stages of pathology. This, together with the fact that the whole subject of bone cysts is comparatively recent, forces me to the conclusion that my cases represent the earliest stage, the stage in which it is most desirable to recognize any disease. It must be borne in mind that there was no enlargement in either case; that in both there was the history of localized trauma, of persistent but not severe pain, and of localized but not typically "wincing" tenderness. In fact, there was the clinical picture of a "chipping" fracture with lingering signs, because untreated. It was only by close scrutiny of the skiagram in the first case for such a chip that the minute cyst was discovered. In the second case detection of the cyst was facilitated by the memory of the first case, which had preceded it by only three months.

As to the pathology, I am unable to present any observations. The cysts were so minute that it would have been unjustifiable to resect the bones in order to study the cysts. At operation, each cyst had a sharply defined globular wall, and the contents resembled the vitreous body of the eyeball. By correlation, however, I incline to the opinion that the cysts are the result of hemorrhagic osteomyelitis, which has been described by Barrie and Hillman,[5] who define it thus: "The term hemorrhagic osteomyelitis is meant to embrace a majority of those traumatic, localized, non-infective (so far as we know at present), non-suppurative, low-grade inflammatory lesions that have their onset in spongy bone." The slight trauma in my cases was sufficient to cause fractures of the delicate normal bone trabeculae, producing effusion, hemorrhage, and interference with nutrition, thereby setting up a localized osteomyelitis. The pigments of the blood were absorbed, leaving clear contents, just as occurs in cysts of soft tissues, notably in pancreatic cysts of hemorrhagic origin.

I have noticed several times minute cysts about the size of the head of a pin in the carpal semilunar in roentgenograms taken for other conditions, but doubt if they were true cysts. A study of trabeculae in roentgenograms shows that cysts may be simulated by certain arrangements of lights and shadows. The best way to avoid error is to correlate clinical findings with those of the roentgenogram.

CONCLUSIONS

1. Cysts of bone should be detected in their incipient stages before extensive destruction of the medulla has taken place.

2. Early operation results in prompt cure, and prevents deformities and extensive bone plastics.

3. A localized trauma followed by persistent but not severe pain, and localized but not true "wincing" tenderness—symptoms and signs of an untreated "chipping" fracture—should arouse clinical suspicion of a minute, early bone cyst, the corroboration of which may be afforded by close scrutiny of a roentgenogram at the site corresponding to that of the localized tenderness.

241 South Thirteenth Street.

1. McDill: Ann. Surg., 1913, lvii, 533.
2. Silver: Am. Jour. Orthop. Surg., 1912, ix, 563.
3. Elmslie: Brit. Jour. Surg., 1914, ii, 54.
4. Jones, Robert: Arch. Roentgen Ray, 1907, xi, 316, 342.
5. Barrie and Hillman: Surg., Gynec. and Obst., 1914, xix, 42.

SUPRAPUBIC PROSTATECTOMY*

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On account of the mortalities occurring, no one is exactly satisfied with his technic in prostatectomy, except for the present time, but naturally he thinks that just now it cannot be improved on.

The men who do the greatest number of operations do not necessarily have the best technic for general use, for that which is easy for the one who knows how may be impossible for the other man. Then, too, the operator before a clinic may devise an operation for "sight seeing" for the spectators that will aggrandize himself at the expense of the patient.

Gentleness, thoroughness with simplicity is becoming the more fashionable prostatectomy. The time is also present when an operator is more easily divorced from a false opinion than heretofore.

Prostatectomy seems to have reached the stage where the lesser points are deemed essential.

There are possibly four principal reasons for the suprapubic operation to carry the greatest preference at the present time:

1. The danger of the pus-bathed perineal tube forcing infection into the torn open-mouthed veins and thereby producing emboli and thrombi.

2. The greater ease of local anesthesia in the suprapubic region.

3. The avoidance of trauma through the pelvic diaphragm.

4. The comparative ease and simplicity of postoperative treatment.

From the results following non-irrigation for the control of hemorrhage, it would seem that irrigation was a menace rather than a benefit, especially when the preoperative preparation endeavors to improve the

* Read before the Section on Genito-Urinary Diseases at the Sixty-Fifth Annual Session of the American Medical Association, Atlantic City, N. J., June, 1914.

fibrin product of the blood. The clot formed in the bladder assists in checking further hemorrhage. Irrigations were necessary only during times past when the drainage-tube lumen was small.

For the same reason that a perineal drainage-tube carries a possible danger of forcing pus into the torn open-mouthed veins, so also is a retained urethral catheter contra-indicated. The fact is that even sounding of the urethral canal is quite hazardous as a late postoperative procedure for fear pus will be forced back through the ejaculatory ducts or out of the vas ampulla to infect the epididymis.

The lack of shock is so marked following operation under local anesthesia that it would seem advisable to operate under local anesthesia in all cases to the farthest degree whereby pain is not felt by the patient, supplementing finally general anesthesia, if necessary, until the prostate is removed, then fixing the drain and closing the wound under the retained local anesthesia.

The most perfect postoperative recovery which I have ever experienced occurred in the following case:

Mr. S., aged 76, Feb. 2, 1914, No. 250-S. The man was young for his age. Following a perfect preoperative preparation the patient was operated on under local anesthesia. The skin from just below the umbilicus to pubes and also the deep linea alba were injected with 1 per cent. cocain solution. All fascial and muscular planes laterally were injected with 1:400 novocain, as well as the bladder wall. After opening the bladder (incision extending 1 inch pubically from peritoneal fold) the prostate was injected deeply with 1 per cent. cocain while the pericapsular region was injected with the 1:400 novocain solution. The operation was painless, except for a short period during the prostatic enucleation. A 1-inch drain was purse-stringed into the roof of the bladder; small cigaret drain to Retzius' space; wound was closed without additional local anesthetic. Patient was put to bed without the Fowler elevation, attended by a special nurse, without irrigation for hemorrhage. The only inconvenience in the convalescence, which by the way was not experienced by the patient, was gas collections in the ascending and transverse colon.

At the Los Angeles session, several years ago, I spoke of the importance of chronic colitis playing an important influence in prostatectomized patients. I still think that the subject does not receive the general attention that it deserves. Old prostatics generally have indolent constipated bowels, which are much influenced by the renal toxemia which has induced, from the years of pathology, a chronic inflammation of the colon. This colic pathology is aggravated by and itself superinduces gas distention which opens up another field for toxic absorption, which added to the overloaded kidneys adds another weight toward dissolution.

The toxemia from the distended colon, even when the kidneys show a fairly quantitative and qualitative urine, is so profound that the temperament of the patient will become so disagreeable, so changed, that the nurses' patience will be tried sometimes to the point of breaking.

I have noted flights of temper in these patients which were entirely unnatural and unnecessary. While the distention was giving the patient no discomfort from pain, yet, just as soon as the distention was relieved, the temperature and temperament of the patient returned to normal. One of the principal thoughts of the surgeon should be in his preparatory treatment to correct and in the postoperative treatment to remove the gas distention of the colon.

THE ULTIMATE RESULTS OF GENITAL TUBERCULOSIS IN THE MALE*

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Genital tuberculosis in the male is a very grave affection. It does not indicate, as many suppose, an infection of the genital tract alone. On the other hand, a careful analysis of many cases shows it to be merely another outbreak of a tuberculous infection which has been smoldering sometimes for years.

In an analysis of 153 cases of epididymal tuberculosis seen at the Massachusetts General Hospital, I[1] found evidence of tuberculosis of other organs, notably lungs, in 35 per cent. In most of these (29 per cent.) the disease was active at the time of entrance to the hospital. In the present series of cases, 154 in all, tuberculosis of organs other than those of the genital tract was found to exist in 55.8 per cent., the lung again being most frequently involved with a total of thirty-five cases, 22.7 per cent. of the whole. Kidney and bone infections came next with seven cases each. Genital tuberculosis is, therefore, to be regarded as but another manifestation of an active tuberculous infection and a lowered resistance on the part of the patient.

Tuberculosis of the genital tract affects the epididymis primarily. So far as I am aware, no case starting elsewhere than in the epididymis has been observed in a now considerable experience; nor, so far as I know, do the records of the Massachusetts General Hospital contain such an instance. Guisy,[2] in 183 cases of genital tuberculosis, found but ten involving the prostate and vesicles alone; while Saxtorph[3] observed only nine in a series of 205 similar cases. Infection starting elsewhere than in the epididymis is, therefore, exceedingly uncommon. In the urinary tract the primary focus is always in the kidney, a fact borne out by ample clinical and pathologic experience.

The general profession is too apt to use loosely the term "genito-urinary tuberculosis." While the genital and urinary organs may each be tuberculous, careful inquiry will show infection of the one tract to be secondary to that of the other. An analysis of the 154 cases now under consideration has shown a tuberculous infection of the kidney in eighteen. Of these, the genital lesion preceded the renal infection in eleven, whereas in seven the kidney was first involved. In one or two other cases, observed by me, but not included here, the latter sequence has also occurred. It is thus seen that the infection extends more often upward than downward, a fact which in my opinion favors strongly the transmission of the tubercle bacillus by the lymphatic route. In those cases in which epididymal tuberculosis of one side is followed by an involvement of the opposite kidney it is to be accounted for by a crossing of the lymphatics at the base of the bladder. If such infection took place by way of the blood-stream it seems reasonable to suppose that the kidney would more often be the primary focus of the genito-urinary tract. On the other hand, one might

* Read before the Section on Genito-Urinary Diseases at the Sixty-Fifth Annual Session of the American Medical Association, Atlantic City, N. J., June, 1914.

1. Barney, J. Dellinger: Am. Jour. Urol., December, 1911.
2. Guisy: Ann. d. mal. d. org. Gén.-urin., 1906.
3. Saxtorph: Cong. Internat. de Chir. Urin., 1900.

argue that a greater resistance of the kidney to the onslaught of the tubercle bacillus was the determining factor in the order of events.

Let us now see what encouragement can be held out to the patient with tuberculosis of the epididymis. Of 154 cases taken from the records of the Massachusetts General Hospital, 113 have been traced since operation. Of these, 31 patients are known to have died of tuberculosis. Eight more have died of other causes, but it seems highly probable that a majority of these were still tuberculous at the time of their death. Sixty are now living. I have personally examined 32 of these men anywhere from two to fifteen years after operation. By letter and otherwise, satisfactory statements of bodily health have been obtained in 28 others now living at from two to twenty-six years after operation. Information as to 13 more, living from one to three years after operation, but since lost sight of, is also included because of certain important facts.

The old saying, "There is no Indian like a dead Indian" is peculiarly applicable to the individual infected with tuberculosis. When we say that until he is dead he is apt to break out with some new manifestation of the disease we are not far from the truth. Four died, in the hospital, within a month after operation, all of miliary tuberculosis, 3 of them so proven by necropsy, giving a figure for the 28, of the 31 whose postoperative length of life is known, of 14.2 per cent. Within the first six months after operation (including the 4 mentioned above) 9, or 32.1 per cent. died, whereas a total of 14, or 50 per cent., succumbed within the first year. From this point, until the end of the sixth year, the death-roll drops rapidly, but we find that during the first six years after operation, 85 per cent. have died. Thus although we see that half of these unfortunates were gathered in by the end of the first year, and over three-quarters of them by the end of the sixth year, it is important to find that 3, or 10.7 per cent. died of tuberculosis between the ninth and eleventh years, a fact which warrants the belief that until at least ten years have elapsed after operation, no patient can be said to be cured. The facts here presented are somewhat different from those of other writers. Lapeyre[4] says that 75 per cent. of these patients are cured, and that a survival of the patients of from four to ten years after operation is to be expected. Brunt and Brungner[5] reported 56 per cent. of favorable remote results, while Haas[6] speaks of 45 per cent. of permanent cures. In my opinion these figures are misleading for the reason that the patients have not been followed over a sufficient number of years. Taking my own cases for a period of six years after operation I find that in a total of 58, of whom I know the definite results, 24, or 41 per cent., have died of tuberculosis.

An analysis of the particular manner in which the tubercle bacillus gave its death blow is illuminating. In 7, or 22.5 per cent., a general miliary process closed the scene, while in an equal number renal tuberculosis was the determining factor. Lung involvement came next in order with a percentage of 16.1 per cent. The cause of death in 10 others was given simply as "tuberculosis" without reference to the organs involved, while "meningitis" and "fistula in ano" each claimed one victim. That these 31 dying of tuberculosis were already doomed seems clear when we see how extensive was the involvement, either in the past or at time of operation, of organs other than those of the genital tract. In 15 (practically 50 per cent.) the lungs were already involved at time of entrance to the hospital, kidney and bone infections coming next in order with 4 cases each. Other tissues and organs such as larynx, joints, meninges, glands and middle ear each contributed their quota. Yet none of these cases, in spite of evidences of tuberculosis elsewhere, was considered by the surgeon as a bad risk.

Of the group now known to be living at periods of from two to twenty-six years after operation (sixty in all), the lungs were affected only 8 times, kidney 3 times, and other organs once or twice each. Among the thirteen heard from within the first year or two after operation, but trace of whom has since been lost, lung tuberculosis was found in three instances.

The extent of the genital lesions of the living and of the dead was about the same. In most a single epididymal infection was found, while the prostate and seminal vesicles were involved in about the same proportion of cases in all groups.

The urines of those now dead contained pus, blood, albumin and casts in various combinations in 77 per cent., while of the patients living the urine was pathologic in but 38 per cent.

The guinea-pig test of the bladder urine in these cases has been sadly neglected both before and after operation. Yet it is a point of the utmost importance, not only for purposes of diagnosis, but also of prognosis. If a positive test is obtained, it shows either that there is renal involvement, or that the bladder has become infected by way of the prostate. Even with the urine free from tubercle bacilli we may find it to contain pus, blood and albumin. These elements, in the presence of marked bladder irritability, may well lead us to suspect tuberculosis of the kidney, and if this exists that organ must be first dealt with. In eight out of ten of this series tubercle bacilli were found in the urine before operation. In six patients now living and seen by me, guinea-pigs have been inoculated with the bladder urine. Four, formerly negative, have since developed tuberculous kidneys and give a positive test. One patient whose kidney was removed for tuberculosis six years before the genital lesion developed now has a urine free from tubercle bacilli. Four other cases are likewise negative, and were so before operation. One of these has since had a relapse in the second epididymis.

Seventeen of the 32 patients seen by me have had a fresh outbreak of tuberculosis since the removal of their first epididymis. In 4 the second epididymis has become involved, while in 4 others kidney tuberculosis (bilateral in one case) has intervened. Three patients have developed ischiorectal abscesses with a persistent fistula in ano, 2 are now suffering from disease of the bone (one of the hip, one of the spine) and 1 case each of phthisis, corneal ulcer, glandular tuberculosis and funiculitis has been seen. In other words, the fire has not yet burned itself out.

Of the 31 who died of tuberculosis, 15 developed tuberculous foci after operation elsewhere than in the genital tract, and succumbed later to additional and more extensive exacerbations of the disease. Thirteen of the 32 patients seen by me have thus far presented a clean score except for the epididymal infection. In most instances they have gained weight and seem to be in perfect health. The remainder are or have been handicapped, as described above, by other manifesta-

4. Lapeyre: Arch. gén. de Chir., July, 1912, No. 7.
5. Brunt and Brungner: German Cong. of Surgeons, 1901.
6. Haas: Beitr. z. klin. Chir., 1901, xxx.

tions of the disease. I have observed elsewhere[7] that azoospermia obtains in tuberculosis of the epididymis (even when unilateral) in 85 per cent. Further observations confirm this statement. I also remarked that the lesion in question did not disturb the sex function. This conclusion is also still sound. Even after double orchidectomy the adult seems to be unaffected as regards his masculinity. Two of our patients, so handicapped, asserted that they were perfectly normal from a sex point of view in regard to both desire and ability to perform the sexual act.

We now have the records of nearly 100 epididymectomies at the Massachusetts General Hospital. I have remarked elsewhere[8] that not one of these patients has yet been obliged to submit to a subsequent orchidectomy. This statement still holds true in spite of the fact that the testicle, in our experience, is clinically tuberculous in 44 per cent. of cases, and microscopically so, in cases of orchidectomy, in 66 per cent. In other words, where experience and judgment are exercised, the testicle need rarely be removed with the epididymis.

In sixty-nine of the patients analyzed here the prostate and seminal vesicles were found to be tuberculous at the time of entrance to the hospital. Many of those now living have since been examined by me at various intervals of time after operation. In most instances the induration, nodularity and tenderness of the prostate and vesicles, present before operation, has subsequently disappeared entirely, or decreased in extent. In a few the condition is the same as before operation. In two instances the process continued after operation, and formed an abscess which opened spontaneously, or was drained, with the establishment of a permanent perineal fistula, from which urine has leaked at times. This experience, although brief and incomplete, substantiates the belief which I have always held, namely, that the prostates (including seminal vesicles) which are markedly tuberculous had best be left alone, and, like those which are only slightly or moderately infected, will generally take care of themselves after removal of one or both epididymes. I regard attempts at complete excision of the tuberculous prostate and seminal vesicles as not only useless but impossible.

A broad view of the whole subect of surgical tuberculosis, and of genital tuberculosis in particular, demonstrates beyond question that, taken all in all, the odds are against the patient. The longer he can live and fight down any particular outburst of the disease the better able he is, in most instances, to overcome the next exacerbation. It all comes down to a question of immunity. Once fortified in this manner a patient can ward off an onslaught of the tubercle bacillus, which, under other circumstances, would get the upper hand in a short time. While we have all seen patients with surgical tuberculosis, who have fought single handed a winning battle for many years, we should not hesitate to bring to their relief the best of hygienic treatment, the regular and continuous administration of sandalwood oil, and the use of tuberculin. The latter should be given only after operation, must be given cautiously and intelligently, and should be employed for an almost indefinite time. Under these conditions whatever natural immunity the patient may possess, or has acquired, will be raised to the highest possible point, a factor which I believe will give the victims of this disease a better outlook in the future than they have had in the past.

7. Barney, J. Dellinger: Boston Med. and Surg. Jour., 1912, clxvi, No. 11.

8. Barney, J. Dellinger: Boston Med. and Surg. Jour., 1913, clxviii, No. 25.

SUMMARY

1. Tuberculosis of the genital tract is accompanied by old or active lesions in other organs in more than 55 per cent. of cases, most of them being in the lung.

2. The genital tract is usually first attacked in cases of genito-urinary tuberculosis.

3. Over 27 per cent. of 113 patients traced have died of some form of tuberculosis. Within a period of six years after operation 41 per cent. of 58 patients have died of this disease. Of the deaths from tuberculosis, 14.2 per cent. occurred within one month, 32.1 per cent. within six months and 50 per cent. within one year after operation. During the first six years 85 per cent. died, while between the ninth and eleventh years 10.7 per cent. succumbed. Miliary, renal and lung tuberculosis are, in order, the final types of the disease. A large majority of those dying of tuberculosis had had one or more outbreaks of the disease both before and after operation. My experience warrants the conclusion that until at least ten years have elapsed after operation, no patient can be said to be cured of tuberculosis.

4. The records of those now living show a much smaller percentage than do those of the dead, of other tuberculous processes before operation, but many of them have since developed other foci. As 81 per cent. of those examined and 28.5 per cent. of those corresponded with are still within the six-year period, in which I found that 85 per cent. of deaths had occurred, it is to be expected that the deaths in this group, from tuberculosis, are not yet at an end.

5. While genital tuberculosis, even if unilateral, results in sterility in most cases, neither the disease nor the operation for its relief, including double orchidectomy, seems to impair masculinity in any way.

6. In none of my cases of epididymectomy has the patient returned for a subsequent orchidectomy, although in three instances (one has already been mentioned) there has occurred a tuberculous funiculitis, simulating testicular involvement.

7. My experience has shown that although the prostate and seminal vesicles are involved in most cases of epididymal tuberculosis, their condition will improve or heal after removal of the epididymis. Radical surgical treatment of these organs is unnecessary and unwise.

8. The long life and good general condition of many of my patients, even although suffering from repeated outbreaks of tuberculosis, shows that the survival of the patient depends largely on his ability to immunize himself to the disease. Therefore our efforts must be directed, not merely toward suitable surgical treatment, but also toward helping him develop that immunity which is so important. For this purpose hygiene, sandalwood oil and tuberculin are essential.

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ABSTRACT OF DISCUSSION

DR. B. C. CORBUS, Chicago: I am particularly interested in the point that Dr. Barney makes with reference to establishing an immunity in these cases. During the last two years I have been interested in the work of Dr. Karl von Ruck of Asheville, N. C., with regard to the immunization of children and adults in general tuberculosis, and have recently done some work in his laboratory. I came to realize the possibil-

ity of immunization before surgical interference is attempted. We all realize how necessary it is to put our patients in the best possible condition to withstand any kind of a surgical operation, no matter what the infection may be, but most surgeons apparently desire to operate as soon as possible in a case of surgical tuberculosis. That it is absolutely necessary to remove every caseous focus that exists, is granted. In immunization before operation, the idea is to use a vaccine that contains all the particles of the tubercle bacillus in proper proportion, a vaccine that will stimulate the formation of antibodies in every part, the patient's serum being tested for these antibodies before operation, so that one can demonstrate whether the patient has a specific resistance. This seems to me to offer more advantage than an immunization afterward.

DR. ROBERT H. HERBST, Chicago: I agree with Dr. Barney that if not in all, in most cases of genital tuberculosis we find the process beginning in the epididymis. The reason for this is obvious if we stop to consider that in the epididymis we find small tortuous blood-vessels on the walls of which the tubercle bacillus readily implants and forms a focus of infection. From a therapeutic point of view I think that it is well to divide cases of genital tuberculosis into two classes: first, those in which the process is limited to the epididymis; secondly, those in which we have to deal with an involvement of the cord, prostate and seminal vesicles. In the first class epididymectomy or orchidectomy with removal of a part of the cord will, as a rule, be followed by good results. In the second class, however, in which the process has extended to the lower end of the genital tract, the patient is far better off without surgery and instead should be relegated to tuberculin treatment with the usual hygiene for tuberculosis.

DR. J. H. CUNNINGHAM, JR., Boston: I have recently looked up the necropsy records of the Boston City Hospital in cases recorded as tuberculous epididymitis. In twenty such cases a microscopic examination was made of the prostate and seminal vesicles. It is interesting to note that, out of these twenty cases, in eleven the disease was bilateral in the epididymis, and in nine it was unilateral. Of these twenty cases the prostate was involved in eleven; the seminal vesicle also in eleven. When the vesicle was involved the prostate was also involved in each instance. Of the eleven bilateral cases of tuberculous epididymitis, involvement of the seminal vesicle was bilateral in seven and unilateral in four. Of the twenty cases the testicle was involved in only four. In two of the cases involving the epididymis, vesicles and prostate the lesion in the epididymis was caseous, suggesting primary tuberculosis in the epididymis, there being an acute miliary infection of all the visceral organs in these two instances. There are unquestionably cases of tuberculous epididymitis in which it is impossible clinically to detect tuberculosis in the prostate or seminal vesicle even when it is there, and the successful dealing with the condition within the scrotum by surgical measures, allows the disease in the prostate and vesicle to remain quiescent or at least not to progress to the point of producing symptoms in most instances. Especially is this true if these patients receive tuberculin and carry out the hygienic measures which have been proved to be beneficial in controlling tuberculosis wherever located. This postoperative treatment is most important after the primary focus is removed, because clinically, as in these twenty cases in which necropsy has been performed, we have found that the majority of the patients with tuberculous epididymitis have associated tuberculosis in the vesicles, prostate or elsewhere in the body.

DR. E. L. KEYES, JR., New York: I have seen but one case of relapse of tuberculosis in the testis after removal of the epididymis. The patient had had one epididymis removed for tuberculosis two years before. At that time he had a tuberculous ischiorectal abscess and fistula which were not touched. The scrotum healed after the removal of the epididymis, the testicle being left in, but broke open six months later. He returned to the hospital, with an extension of the process around the rectum, involvement of the opposite epididymis and a relapse in the testicle which had been left behind after the removal of the epididymis. I agree with Dr. Barney that the testicle can always be saved when it is mechanically possible to remove the epididymis and still leave the testicle some blood-supply, but I wish to report this single instance of recurrence after apparent healing subsequent to epididymectomy.

DR. J. D. BARNEY, Boston: I understood Dr. Herbst to say that in cases in which the prostate and vesicles were involved, surgery had better not be done. We have found in a previous analysis of a great many cases that in 75 per cent. the prostate and seminal vesicles are involved, and I made the remark then that probably a great many more were involved that we could not detect because it is possible in the vesicle and prostate to get early foci which cannot be felt with the finger. I think 75 per cent. is conservative. If one goes on the basis of these figures and if one adopts Dr. Herbst's belief it leaves a very small percentage that can be operated on. I have shown the results in a great many cases in which the prostate and vesicles were distinctly involved before operation and in which they are now so nearly healed that it is very hard to detect any tuberculous foci in them. That, it seems to me, is the answer to this objection.

OBSERVATIONS OF THE RESULTS OF SEVEN MONTHS' EXPERIENCE WITH SALVARSAN IN THE TREATMENT OF SYPHILIS

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In March, 1914, we published[1] the results of our observations with neosalvarsan in the treatment of syphilis. This report showed that after five intravenous injections of neosalvarsan combined with intensive mercurial treatment, the Wassermann reaction had become negative in 33.3 per cent. and remained positive in 66.7 per cent. of the cases treated. These results were considered so poor that it was believed a further use of neosalvarsan at this institution was not warranted. Since Jan. 10, 1914, salvarsan has been substituted for neosalvarsan, and the results of that substitution are here recorded.

Seventy-four cases of syphilis have been treated at the Prison Hospital during the past seven months. Twenty-five of these cases have been selected for report in this paper. These twenty-five cases have received their entire treatment at the Prison Hospital, and the original and all subsequent serum tests have been performed by the same medical officer (Capt. Charles Craig, Medical Corps, U. S. Army). In the remaining forty-nine cases the treatment was started elsewhere, the original Wassermann test having been made by other medical officers; in short, the treatment of these cases was simply continued at this institution.

Each patient here reported has received four intravenous injections of 0.6 gm. of salvarsan and twelve intramuscular injections of 100 mg. of the salicylate

1. Nelson, Kent, and Haines, E. F.: Observations of the Results of Nine Months' Experience with Neosalvarsan at the United States Military Prison Hospital, Fort Leavenworth, Kan., THE JOURNAL A. M. A., March 28, 1914, p. 989.

of mercury. The salvarsan has been given at ten-day intervals, the mercury, two injections a week. No bad effects from the intramuscular injections of the mercury have been noted. The prisoners here are all engaged in active outdoor work, and state that they have felt no discomfort in the muscles following injections. The intravenous puncture has been employed in each administration of salvarsan.

Table 1 shows that no reaction followed the administration of salvarsan regardless of the stage of the disease. It has been stated by some that there are

TABLE 1.—REACTIONS ACCORDING TO THE STAGE OF DISEASE

Stage of Disease	Number of Cases	Total Number of Injections	Reactions				Percentage of Negative Reactions
			Severe	Moderate	Mild	None	
Primary	1	4	0	0	0	4	100
Secondary	17	68	0	0	0	68	100
Tertiary	1	4	0	0	0	4	100
Latent	6	24	0	0	0	24	100
Total	25	100	0	0	0	100	100*

* Average negative.

a greater number of reactions following the use of salvarsan than when neosalvarsan is used. The cases treated at this hospital do not bear out this statement. We consider all cases severe in which the temperature is above 102 F., with or without other symptoms; moderate, when the temperature ranges from 100 F. to 102 F.; mild, normal temperature to 100 F. Cases are deemed as having no reaction when there are no high temperature and no symptoms.

An analysis of Table 2 shows that 64 per cent. of the cases here reported have become negative and 36 per cent. remained positive. Our report on neosalvarsan showed that after each patient had received five intravenous injections, combined with intensive mercurial treatment, 33.3 per cent. became negative, and 66.7 per cent. remained positive. In other words,

TABLE 2.—THE RESULTS OF TREATMENT WITH SALVARSAN ON THE COMPLEMENT-FIXATION TEST IN THE VARIOUS STAGES OF SYPHILIS

Stage of Disease	Total Cases	Became Negative		Remained Positive	
		No.	Per Cent.	No.	Per Cent.
Primary	1	1	100	0	0
Secondary	17	12	70.7	5	29.3
Tertiary	1	0	0	1	100
Latent	6	3	50	3	50
Total	25	16	64	9	36

with salvarsan we have obtained nearly twice as many negative reactions as with neosalvarsan, 64 per cent. of the cases becoming negative against 33.3 per cent. with neosalvarsan. Five intravenous injections of neosalvarsan were used, where only four of salvarsan were given. It was stated in our report on neosalvarsan that the results of our work with that drug did not seem to warrant the belief that neosalvarsan should be given in the proportion of 3 to 2 of salvarsan, but that it should be given either 6 or 8 to 2. The results that have now been obtained with salvarsan seem to prove this statement, for four injections of salvarsan have given nearly twice as many negative Wassermann reactions as did five injections of neosalvarsan.

Repeated Wassermann tests have been made in all the cases here reported, all by the same medical officer (Capt. Charles Craig) who likewise made all of the serum tests of the cases reported in our work on neosalvarsan. We have thus secured an absolute uniformity of technic and interpretation of the serum reactions, thus giving accurate data regarding the results of our treatment as indicated by the Wassermann reaction.

Table 3 shows that out of 16 cases that became negative, 5 were during the first month, 9 were negative by the second month, 13 by the third month, and 15 at the end of the fourth month. In other words, 15 of the 16 negative results were obtained by the end of the fourth month. In our report on observations with neosalvarsan, a similar table to Table 3 of this paper showed that out of 68 cases 23 became negative. One the first month, 1 the second, none the third, 3 the fourth, 3 the fifth, 4 the sixth, etc. In other words, at the end of four months, 5 of our cases out of a total of 23 negative had shown a

TABLE 3.—RELATION OF THE STAGE OF SYPHILIS TO THE TIME OF DISAPPEARANCE OF COMPLEMENT FIXATION AFTER TREATMENT WITH SALVARSAN

Stage of Disease	Total Cases	Month							Total Negative
		1st	2d	3d	4th	5th	6th	7th	
Primary	1	..	..	..	1	..	..	..	1
Secondary	17	4	3	3	1	..	..	1	12
Tertiary	1	..	..	..	..	..	..	..	..
Latent	6	1	1	1	..	..	..	..	3
Total	25	5	4	4	2	..	..	1	16

TABLE 4.—RELATION OF THE INTENSITY OF THE COMPLEMENT FIXATION TO THE DISAPPEARANCE OF THE REACTION AFTER TREATMENT WITH SALVARSAN

Character of Reaction*	Total Cases	Became Negative		Remained Positive	
		No.	Per Cent.	No.	Per Cent.
++	14	6	42.8	8	57.2
+	6	6	100	0	0
+—	5	4	80	1	20
Total	25	16	64	9	36

* A ++ reaction represents an absolute inhibition; a + reaction, any degree between 75 per cent. and absolute inhibition; a +—, any degree between 50 per cent. and absolute hemolysis.

negative reaction; or, more briefly stated, with neosalvarsan 21 + per cent. of our negative cases showed the negative reaction within four months, whereas with salvarsan 93 + per cent. of the negative cases showed the negative reaction within four months. This demonstrates very clearly the rapidity of action of the two drugs.

A study of Table 4 shows that the stronger the serum reaction, the fewer cases that became negative. With a ++ reaction 42.8 per cent. became negative, with a + reaction 100 per cent., and with a +— 80 per cent. These results do not differ in any material way from those obtained by us with neosalvarsan.

Table 5 shows that in the 6 negative ++ cases all of the negative reactions were obtained by the end

TABLE 5.—RELATION OF THE INTENSITY OF THE COMPLEMENT FIXATION TO THE TIME OF DISAPPEARANCE OF THE REACTION AFTER TREATMENT WITH SALVARSAN

Character of Reaction	Total Cases	Month							Total
		1st	2d	3d	4th	5th	6th	7th	
++	14	1	1	2	2	..	..	..	6
+	6	2	2	2	..	..	..	..	6
+—	5	2	1	..	..	..	..	1	4
Total	25	5	4	4	2	0	0	1	16

of the fourth month; that all of the + cases were negative by the end of the third month; and 3 out of the 4 negative +— cases were negative by the end of the second month. In our report on neosalvarsan 40 ++ cases were recorded, 13 became negative, but

at the end of the fourth month only 2 of the 13 had shown the negative reaction. Nineteen + cases were reported, 6 of which became negative, 2 showing the negative reaction at the end of the fourth month. Nine + — cases were recorded; 4 became negative, only one of which showed a negative reaction by the end of the fourth month. A study of Table 5 shows clearly as does Table 4 the more rapid action of salvarsan.

CONCLUSIONS

1. Four injections of salvarsan combined with intensive mercurial treatment have given nearly twice as many negative serum reactions as did five injections of neosalvarsan with mercurial treatment.

2. The best authorities state that with our present methods of treating syphilis we cannot expect to obtain over 70 or 80 per cent. of negative Wassermann reactions. Salvarsan has given us 64 per cent. of negative serum reactions, whereas neosalvarsan gave 33.3 per cent. in nine months.

3. The drug should be used which will bring about the best results in the shortest possible time. We believe that our work with neosalvarsan and salvarsan will clearly demonstrate that salvarsan is the drug.

4. A greater number of reactions should not follow the use of salvarsan.

5. The complement fixation is of the greatest value in diagnosis, or as an indicator to the results of treatment.

6. We believe that the results reported in this paper are of such a character as not to warrant the further use of neosalvarsan in the military service; and to all others who desire to give their patients the best possible results in the shortest possible time.

FACTORS GOVERNING VASCULAR DILATATION AND SLOWING OF THE BLOOD-STREAM IN INFLAMMATION*

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Inflammation is a process characterized by symptoms which have been referred, directly and indirectly, to changes in caliber of blood-vessels, and to other less definite changes which are grouped under the term "changes in permeability" of vessel-walls. The changes in caliber have been used in explanation of the increased redness and of the apparent increase in temperature of an inflamed area. The phenomena of exudation, including emigration and diapedesis, have been referred to "changes in permeability." These latter phenomena always follow the former.

Vascular dilatation is a normal, physiologic process by which the blood-supply of an organ is increased during physiologic activity. It is an adaptive mechanism. It occurs under any circumstances which bring about increased metabolic activity, and appears under all sorts of conditions which are unassociated with the symptoms or morphology of inflammation. Nevertheless, it is a fundamental phenomenon of the inflammatory process; therefore, in discussing that process, it is necessary to offer an explanation of vascular dilatation.

* From the Department of Pathology, University of Cincinnati.
* In the following pages I have attempted to correlate a considerable amount of experimental data which has accumulated on the subject of vascular dilatation.

It has been said that the dilatation of the blood-vessels is due to paralysis of the vasoconstrictors, to irritation of the vasodilators or to both; or, finally, to paralysis of the muscular fibers of the arterioles. It was shown by Cohnheim, however, and the fact has been substantiated by more recent workers, that the vasomotor nerves play no essential part in the phenomenon of dilatation in inflammation. Cohnheim said that "the vessels are wont, under the influence of the agents employed by us, to dilate very much more than is ever the case in paralysis of the vasoconstrictors or stimulation of the vasodilators," and he also called attention to the fact that if croton-oil were rubbed on a rabbit's ear, a considerable time might elapse before the evidences of dilatation appeared. If the nerves were active the dilatation should appear promptly and not be delayed. The reaction is delayed. Adami suggests that "section of all the nerves passing to any region of the body should have such an effect, that injury should be unaccompanied by the ordinary vascular reaction," were the nerves alone the cause. The reaction, however, occurs. Moreover, while it is true that an active hyperemia may be induced by removal of vasomotor influences, the congestion may be increased by the use of croton-oil or heat. The events occur in the same order and in the same degree, though at a different rate, if all nervous influences be excluded. Removal of nervous influences, therefore, has no essential effect on the vascular dilatation of inflammation, and the whole inflammatory process may proceed normally in the absence of nervous activities. So it appears that none of the phenomena of inflammation are governed by the nervous system, and that nervous influences have the same importance in inflammation as in other processes, namely, in merely modifying the process—increasing or decreasing the rapidity of its production.

Cohnheim believed that the phenomena of inflammation were the results of molecular changes in the vessel-walls, and definitely stated his belief in the chemical nature of the process. He said that a change of chemical character is undergone by the vessels in inflammation, and that this brings about atony of the muscular coat, which permits dilatation, increase in frictional resistance, and permeability. It was only many years after these statements were made that any definite information commenced to accumulate as to the actual course of events.

Gaskell and Langley have suggested that vascular dilatation "in muscle and perhaps elsewhere" might be due to products of metabolism formed by the activity of the tissue, and Gaskell, later, showed that lactic acid causes dilatation of the vessels of the frog and that even in very low concentration, acids tend to produce vasodilatation. Still later, Bayliss showed that lactic acid and carbonic acid were equally effective in causing dilatation of blood-vessels. Schwarz and Lemberger, and later, Ishikawa, showed that weak acids, which are produced as a result of increased cellular activity, bring about vascular dilatation. In 1907 the evidence had accumulated to such a degree that Verworn formulated the rule that "the increase of the blood-supply in a functionally active organ must be based on a physical self-regulation which takes place as a result of the fact that metabolic products of the tissue cells influence the cells of the vessel-walls in that part so that the vessels dilate and more lymph is formed."

In 1912, Starling said that the great increase in the blood-flow through muscles during muscular exercise is probably brought about largely by chemical means. "It has been shown," he said, that "the presence of blood containing lactic acid or carbon dioxid causes a marked dilatation of the blood-vessels of a limb." Hooker called attention to the fact that carbon dioxid, in minimal effective amounts, always relaxes vascular muscle. Still more recently Markwalder and Starling have shown experimentally that carbon dioxid is directly effective in producing dilatation of the coronary arteries and of the heart itself. They have also shown that "the most potent agent in causing dilatation of the coronary vessels is non-volatile metabolites produced by the heart muscle.[1]

It seems possible that the vascular dilatation of inflammation is merely an exaggeration of a normal process and that the differences which exist between the two are due to variations in the duration of the circumstances which condition the reaction, and in the intensity of the reaction. The matter may be stated in this way: When sufficient chemical damage is done to the vessel-walls to produce a dilatation of a certain degree, the same influence which conditions the dilatation produces other changes in the vessel-walls which permit of exudation. In other words, the dilatation is merely the expression of the action of influences which are acting, in point of time and intensity, beyond the physiologic limits. Under physiologic conditions the blood-flow is increased during the dilatation. Under abnormal conditions it is first increased and then slowed. It is only when the point of slowing beyond normal limits is reached that the process becomes pathologic. Under physiologic circumstances an increase of metabolites causes dilatation, and this effect is due to changes in the vessel-walls which make possible a more rapid flow of blood through the vessels, and an increased oxygen delivery to the tissues, together with increased water transport (as is shown by the increased lymph-flow). In inflammation the dilatation is more marked, is less transient, the blood-stream is eventually slowed, and, beside an increased water transport, there is also a movement of blood-cells which follow the stream of water through the vessel-walls.

Perhaps this may be stated as follows: After an injury to any organ or tissue the local conditions are such that increased metabolic activity is required. There is more than the physiologic amount of useless material to be removed. Some of this must be so changed, chemically, that it can be used as food by neighboring cells. Useless material must be carried away to the sewers of the tissues—largely the lymphatics. To do this work the healthy tissue-cells must increase their activities, and, as a result of this, there must be a local increase of metabolic end-products (metabolites), including carbon dioxid and other substances which latter depend partially on the tissue involved. Any disturbance of equilibrium in the tissues produces profound variations in the chemical activities of the cells, with the result that they overproduce substances which, reacting on the intracellular and intercellular substances, change their physical state. Even the movements of migratory cells are modified under such circumstances. It is such changes in chemical activity which lead to increased production of carbonic acid and lactic acid, which, as has been shown, produce vasodilatation.

Many writers, and most recently and most convincingly, Martin Fischer, have shown how acids influence water absorption and secretion. When tissue is destroyed and when metabolism is increased an accumulation of acids tends to occur. The presence of acid causes swelling of the protoplasm of all the cells in the zone of action. Vascular and extravascular cells and intracellular substance are alike involved. This swelling of the colloidal substances produces several effects: it leads to a decrease in tone of the musculature of the blood-vessels, and it increases the viscosity of the endothelium.[2] The loss of tone is the important factor in the dilatation of the vessels, for were the tone to remain normal it is probable that no more than a very transient dilatation would take place in any vessel possessing a muscular coat. A transient dilatation is a physiologic process. Loss of muscular tone depends, apparently, on physicochemical conditions in the muscle-fibers which render them less ready to contract. It amounts to fatigue, and is quite analogous to the loss of cardiac tone produced by fatigue of the myocardium, which results in cardiac dilatation. (After all, the heart is merely a modified blood-vessel so that what is true for other parts of the circulation should be equally true for it.) A fatigued muscle—cardiac, vascular, or skeletal—is more easily stretched than a normal one. It seems then, in the heart as in the blood-vessels, that accumulation of metabolites or lack of oxygen leads to conditions which are analogous to fatigue, and when in this condition the muscle-fibers are capable of being stretched by a normal blood-pressure or even by one which is lower than normal.

Dilatation of blood-vessels is due then to physical and chemical changes in the musculature which are produced by deficient oxidation and accumulation of metabolites including carbon dioxid. Normally this dilatation is more or less transient and is unassociated with exudation. In inflammation it is more or less permanent and is associated with exudation.

Following dilatation, in inflammation, the blood-stream becomes slower than it normally is in the absence of the inflammatory process. For many years this phenomenon has been attributed to increased frictional resistance between the blood (particularly the blood-cells) and the vessel-walls. It has been said, for instance, that the leukocytes act as though they were sticky. And yet no satisfactory explanation has been used to account for this stickiness. Still, it seems, the accumulated evidence makes it seem possible to discuss this phenomenon in more fundamental terms than was formerly possible, and to apply the physicochemical facts of dilatation to this question of slowing of the blood-stream.

In studying this phenomenon (of slowing) under the microscope one of the earliest things noticed is a moderate swelling of the endothelial cells of the capillaries, a swelling which resembles in some respects that seen when one adds a drop of dilute acetic acid to a suspension of cells of any origin. This endothelial swelling precedes, though briefly, the slowing. Somewhat later the blood-cells themselves begin to swell, and when both these phenomena of swelling are noticeable the stream has already begun to slow. This

1. Kubota (Mitt. med. Gesellsch. Tokio, 1913, xxvii, No. 21) has recently said that the vascular dilatation occurring as a result of stimulation of the vasodilators is dependent on an increase in acidity in the products of metabolism (Ztschr. f. Biochem. u. Biophys., 1914, xvi, 194.)

2. It is of course obvious that the question of viscosity in this connection is an extremely complicated one. Nevertheless, there is evidence that variations in acidity or alkalinity produce increases of viscosity in blood-serum and, therefore, in the tissue (cellular) colloids.

swelling is due to the presence of acids, which, as is well known, cause swelling of the colloidal substances of the tissues, including the intercellular substances. It is entirely possible that other substances than acids (urea?) may produce it. However that may be, it has been shown by many writers that the various acids which occur normally and pathologically in the tissues, are active in this respect. It seems to be true that in simple edema the swelling is due to the presence of various acids.[3] Bechhold says that edema fluid from which the carbon dioxid is removed is acid to phenolphthalein, and Strassburg and Ewald had previously shown that the carbonic acid content of edema fluid is higher than that of venous blood. Moreover, Hoppe-Seyler found, in similar fluids, valerianic, succinic, butyric and lactic acids. If this is true in simple edema fluids it is certainly equally true of the liquids present in such an abnormal process as inflammation, in which metabolism is modified to a greater degree. We should expect to find the same acids present in greater amounts, and we might expect to find others also, for instance, beta-oxybutyric and aceto-acetic acids.

Many writers have shown that increases of carbon dioxid or decreases in oxygen in the blood are productive of cellular swelling. Limbeck says that the volume of the blood-corpuscles varies according to the carbon dioxid content. Koranyi and Bence commented on the fact that, in the presence of carbon dioxid, the blood-corpuscles take up water from the serum, and, recently, L. F. Henderson has stated the modern conception of the normal influence of carbon dioxid on the blood-cells. He says:

> In each complete cycle of the circulation there occurs a complete cycle of changes between the constituents of the corpuscles and the plasma. As the blood flows through the tissues and receives CO_2, the volume of the red blood-corpuscles increases from entrance of water coming from the plasma, chlorin simultaneously passing in the same direction. In the lungs, with the escape of carbonic acid, the process is reversed. There seems to be no doubt that this process is largely dependent on changes in reaction, accompanying changes in the concentration of carbonic acid.

If this be true in the normal process, the same features of cellular swelling must be more marked in the abnormal, especially since the latter are largely accentuations of the former.

It must be apparent that, aside from any changes in consistency, this cellular swelling must produce a purely mechanical effect on the rate of the blood-flow. For if endothelial cells and blood-corpuscles increase in volume then the blood-stream must be interfered with to at least a certain minimal extent. This is of some importance, because a maximum of oxygen is needed at the point of injury, and any decrease in the rate of the blood-flow will diminish the supply of that element. Araki and Zillessen have shown that every loss of oxygen results in increased production of acid.

There is abundant evidence that carbonic and other acids have other effects than mere increase in volume of the cells. The one which interests us at this point is viscosity changes. Bechhold says, in this connection, that acids bring about increased viscosity of albumin. He says, further, that the ionization of albumin is increased by acids, and that the albumin ion shows a higher viscosity than albumin in the undissociated state. Hoeber has brought evidence that increases of carbon dioxid in the blood run parallel with hydrogen-ion concentration, and Pauli and Handovsky have reported that ionization of serum albumin depends on hydrogen-ion concentration, which in its turn is the cause of increased viscosity. Adam found that saturation of the blood with carbon-dioxid produces a maximum increase in viscosity, and he further found that if the carbon dioxid were replaced by oxygen, the viscosity would sink to a minimum, and again increase with carbon dioxid additions. Koranyi and Bence likewise showed that the viscosity runs parallel with the carbon dioxid content. Blunschy said that ventilation of the blood reduces viscosity and reported that although seven hours of skiing lowered the viscosity of the blood 14 per cent. one and a quarter hours of forced exercise in a closed room raised it 4.5 per cent. He also found that venous blood-corpuscles exhibited a higher viscosity than arterial ones. Determann and Hess demonstrated the fact that the blood was increased in viscosity during stasis. W. Ostwald states that a pure albumin, prepared from blood, reacts exceedingly promptly to small traces of acids. He has demonstrated that in albumin solutions the changes are enormous. For instance, an addition of 0.015 normal hydrochloric acid increases the viscosity from 1.0623 to 1.2937. He further says that the maximum increase occurs with 0.02 normal hydrochloric acid. With other acids the maximum is higher.

There are numbers of other citations that might be used in this connection. Those given will, however, suffice for the point. They show, I believe, that decrease in the rapidity of the blood-stream in inflammation is the result of two factors: increase in volume of the cells of the blood and of the endothelial cells lining the blood-vessels, and increased viscosity of the blood as a whole. It has been suggested that both these factors depend on abnormal production of carbonic and other acids.

During exercise, in the normal individual, the carbon dioxid production runs above the normal during rest. This increase is sufficient, as has been shown, to produce a transient vascular dilatation by which the oxygen supply is increased sufficiently to take care of the moderate acid increase, and to counteract it. In the inflammatory process, however, the acid accumulation is too rapid to allow of immediate drainage. The cells are rapidly affected, and the circulation is slowed. This results in still greater disturbances of oxidation and other acids than carbonic acid accumulate. These acids produce still greater changes in viscosity and swelling and eventually the circulation is completely stopped. The experiments of Amberg and Knox, Amberg, Loevenhart and Grove, and Loevenhart and Eyster, support this conception. Loevenhart and Grove produced evidence that the oxygen in such compounds as sodium iodosobenzoate and iodoxybenzoate is physiologically active and capable of being utilized by the body for purposes of physiologic oxidations, and, later, Loevenhart and Eyster showed that those substances give up some of their chemically active oxygen in passing through the tissues. Amberg and Knox showed that such substances reduce the inflammatory reaction when they are introduced into the circulation.

3. If the recent statements of Michaelis (Deutsch. med. Wchnschr., 1914, No. 40, p. 1170) holds, then there is some basis for believing that normal water transport from the capillaries is a matter of variations in acidity. Michaelis says that while the blood maintains an exact grade of alkalinity ($H = 0.45 \times 10^{-7}$) the tissues are neutral ($H = 1.5 \times 10^{-7}$).

The basic fact in all this seems to be the relative (eventually absolute) lack of oxygen, a fact to which Cohnheim first called attention when he said that the slowing of the blood-stream was proportional to the decrease of the oxygen supply.

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AN UNUSUAL FORM OF BIRTH PALSY

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During a difficult or protracted labor and especially in instrumental deliveries, nerve plexuses or individual nerves may suffer more or less considerable damage. Palsies of limbs or segments of limbs follow. The most frequent occurrence is the well-known Duchenne-Erb or upper arm type of paralysis. Here the injury is done to the brachial plexus either by direct pressure with the obstetrician's finger or hook which attempts to bring out of the pelvis the overextended arms or else by pressure with the blade of the forceps. The damage is done either in the axilla or in the supraclavicular region. The forced elevation of the arm within the pelvis may *per se* produce a traction on the brachial plexus or a compression of some of the roots of the latter between the drawn back clavicle and the transverse processes of the cervical vertebrae. The following muscles are involved in this form of birth palsy: deltoid, biceps, brachialis anticus, supinators, supraspinatus and infraspinatus muscles. Their palsy is dependent on the involvement of the roots of the fifth and sixth cervical nerves. The position of the arm is so characteristic that its recognition presents no difficulty. The humerus is rotated inward, forearm extended and hand pronated.

Besides this classical type of palsy occurring during birth other forms have been observed.

The *inferior plexus palsy type*, which is characterized by paralysis of the flexors of the hand, thenar, hypothenar and interossei muscles, and also by oculopupillary symptoms (myosis, retraction of the eyeballs, narrowness of the palpebral fissure), is caused by a lesion of the seventh and eighth cervical and first dorsal roots. This form of paralysis may occur during birth.

The *complex type*, namely, a combination of the upper and lower forms of brachial palsies with the predominance of one over the other, and extension to neighboring roots have also been observed in instrumental deliveries.

Individual nerves may be injured in difficult deliveries.

A lesion of the *circumflex nerve* and consequently paralysis of the deltoid muscle alone have been recorded.

Bilateral palsy was seen by Jolly. In such cases the upper arm is usually spared. The forearm and hand, and also the pectoralis major, latissimus dorsi and triceps are involved. The fifth and sixth cervical roots are evidently intact.

The following case is an example of still another variety of obstetric palsy which appears to be an unusual occurrence, as in the literature at my disposal I was unable to find a similar case:

The infant whose photograph is here appended was born at term but with great difficulty. Dr. Charles Mazer, through whose courtesy I was able to study this case, reports that there was a breach presentation and forceps was applied in the mento-occipital position for a final delivery of the head.

The peculiar feature about the palsy is that first of all it is bilateral, symmetrical and identical in the two forearms. The paralysis is confined to the flexors of the wrists exclusively. When the child is pricked with a pin or when she cries, the arms are raised perfectly. She is seen to be able to elevate, abduct, adduct, rotate, pronate and supinate the arms and forearms. The wrists remain extended in all these movements. The fingers are all flexed as in a normal condition. On the photograph the right arm is seen raised and the elbow flexed during the act of crying when the right upper limb was pricked with a pin.

In order to obtain perfect extension of the wrists, namely, equally on the radial and ulnar sides, two muscles which control the flexion of the wrist must give way to the extensors. They are: the flexor carpi ulnaris and the flexor carpi radialis. The first is innervated by the ulnar nerve and the second by the median nerve.

As the fingers remain flexed in spite of the extension of the wrist, it is evident that there is integrity of the flexors digitorum sublimis and profundus which control the flexor function of the second and third phalanges, also of the interossei muscles which flex the first phalanx.

The nerves supplying the flexors carpi arise in the upper third of the forearm on the ulnar and radial sides. Is it plausible that an injury, such as compression or contusion, should occur at that particular level and produce a lesion of one special nerve filament without involving other closely located nerves and muscles? The manipulations during an artificial delivery when the arms are elevated in the pelvis are such that pressure is exercised directly on the brachial plexus, or else the arms may be so overstretched that the damage produced in the plexus may be caused by overdistention of the latter. It stands to reason that a lesion of any of the branches of the brachial plexus is apt to be involved. It depends on the size of the area pressed on. The position of the arms in the pelvis at a given moment may be such as any manipulation from outside may involve a large or a small nerve of one or another bundle.

In the case recorded here evidently the two branches of the median and ulnar nerves supplying the flexor carpi radialis and flexor carpi ulnaris, respectively, became involved during the accoucheur's manipulation. The damage was done to those filaments of the seventh and eighth cervical roots which enter into the formation of the ulnar and median nerves but which become separated from the main trunks at the level of the upper third of the forearm to enter the corresponding muscles.

The case is interesting from several points of view:

1. The unusual seat of the palsy. I found no similar occurrence in the literature at my disposal. It adds, therefore, a new variety of birth palsy to those mentioned above.

2. The bilaterality of the palsy and its symmetrical distribution.

3. The strictly precise limitation of the lesion to the nerve filaments supplying two muscles having identical function on the radial and ulnar sides, namely, flexor carpi ulnaris and flexor carpi radialis.

1812 Spruce Street.

Preventogram.—A few days' precautions on your part, in case your child is ill, may save the life of your neighbor's child.—Pittsburgh *City's Health*.

EARLY RECOGNITION OF PULMONARY TUBERCULOSIS BY STUDY OF LYMPHOCYTIC PICTURE AND ALBUMIN CONTENTS OF SPUTUM

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Since the discovery of the tubercle bacillus by Robert Koch in 1882, the examination of the sputum of a suspected tuberculous individual has rested chiefly in demonstrating either the presence or absence of the bacillus. In many cases a diagnosis has been based entirely on these findings, more particularly in cases of doubtful physical signs. It is now well known that a sputum negative as to Koch's bacillus does not exclude pulmonary tuberculosis even in the presence of either negative or positive physical findings.

In recent years much work has been done to aid the diagnostician in arriving earlier at more definite conclusions, and this labor has demonstrated that much can be learned from a study of the various components of the sputum both chemically and microscopically, particularly at a time when the sputum is supposed to be still free from the bacillus and the tuberculous process is yet in its preincipiency or has not progressed far beyond that stage. It is now generally accepted that the presence of the albumin content in the sputum is in itself not conclusive evidence of a pulmonary tuberculous process in the absence of tubercle bacilli. It is, nevertheless, in a great many instances a determining factor in sputum analysis.

In combining the chemical examination of the sputum for the presence of albumin with the microscopic study of the picture presenting in the field, but in the absence of tubercle bacilli, we may arrive in many cases of suspected tuberculosis at a more definite conclusion and earlier than is possible by either method alone. Attention was first called to the increase of a cellular element in the sputum as an early sign of a tuberculous pulmonary infection by Wolff-Eisner in 1907. He directed observation to a noticeable increase in the small mononuclear lymphocytes in the sputum in many cases of beginning tuberculous pulmonary disease and to the fact that the total increase of these small cells may number all the way from 33 to 90 per cent.

The presence of the small mononuclear lymphocytes in body fluids other than sputa is considered fairly clear evidence of the presence of an active tuberculous process; and this all goes to stamp tuberculosis per se as a lymphocytic disease. In cytodiagnosis it is a great aid in determining if the aspirated fluid is of a tuberculous nature, and a preponderance of these small lymphocytic cells in the fluid is always considered as being from a tuberculous source. For instance, in an acute pleural exudate showing more than 50 per cent. of lymphocytes the diagnosis of a tuberculous infection is justifiable, and in a meningeal exudate of a tuberculous nature 90 per cent. of all cells are mainly lymphocytes. Again, in a tuberculous peritonitis, which is usually of mixed infection, the exudate contains many lymphocytes, degenerated polynuclears and mononuclear leukocytes; still the frequency of the small lymphocytes points to a tuberculous nature and the same undoubtedly applies to sputum as being that derived from a tuberculous source.

In a suspected, beginning pulmonary tuberculosis the presence of a lymphocytic picture of the sputum under the microscope should stimulate a persistent search for the bacillus, and although they may be so few that they may escape detection entirely even after repeated examinations, such lymphocytic sputum, if most carefully observed at frequent intervals and over long periods of time, will sooner or later demonstrate the presence of Koch's bacillus. If now with such a microscopic observation we combine a chemical sputum analysis for the presence of albumin according to the methods advanced by Roger and Levy-Valanci and many other competent and accurate observers, we may arrive at a positive conclusion and clinch our diagnosis away in advance of being able to demonstrate the presence of the tubercle bacillus.

One hundred and ninety-nine samples of sputa obtained from suspected tuberculous individuals were very thoroughly examined; in nearly all cases a most careful search was first made for the presence or absence of the Koch bacillus; then in addition a painstaking study of the presenting microscopic sputum picture as to the preponderance of the small corpuscular element, and lastly this was verified by a chemical examination for the presence or absence of the albumin content. Out of this total of 199 sputa examinations, 53 were bacilli positive and were designated as sputa obtained from positively tuberculous individuals; 40 out of the 53 also gave in addition a positive albumin test, 2 giving a negative index, and in 11 the albumin test was made but not recorded. Out of this number, 40 also gave in addition a distinct lymphocytic picture, showing a preponderance in every field of the small mononuclear cells; in 8 lymphocytosis was absent, that is, no noticeable increase in small cells; 2 gave a distinct leukocytosis and in 3 no record was filed.

If in this way we can dispose of 53 samples of sputa as positive, as shown by the presence of the tubercle bacillus, irrespective of the presence of the albumin content, or of the lymphocytic picture, there still remain 146 specimens which are bacilli negative and which should be classified by further observation as either positively or negatively tuberculous sputa. Out of this number of 146 sputa examinations in which no bacilli were found on careful and repeated tests, 40 gave a distinct lymphocytic picture and an albumin content in variable amounts. Can these 40 specimens be considered sputa procured from tuberculous individuals in the absence of positive bacilli findings? If lymphocytosis is as characteristic of tuberculous sputa as it is of the serous effusions in the tuberculous; in fact, if tuberculosis is a lymphocytic disease, then these 40 sputa samples can be considered as expectorated material obtained from presumably tuberculous subjects, all these examinations in each case strengthened and controlled by a positive albumin content. Now 34 more sputa examinations out of the same series showing the tubercle bacillus absent gave a negative lymphocytic picture under the microscope, but a positive albumin content in variable amounts by chemical analysis, whereas 17 others, also bacilli negative, were also negative for albumin but positive for the mononuclear cells, showing a lymphocytosis of more than 50 per cent. Again, can these 17 sputa samples with a positive lymphocytic content, but negative for albumin, also be considered samples of expectorations secured from tuberculous subjects?

It is much more in evidence that sputa presenting a distinctly lymphocytic picture with a positive albumin content in the absence of tubercle bacilli speak very probably for tuberculosis, but in the absence of albumin in an otherwise positive lymphocytic sputum the evidence is not quite so conclusive and yet it points very strongly as being of tuberculous origin.

It may be of interest at this point to refer to a few case histories in which the sputum examination under the microscope gave a field in which the small mononuclear lymphocytes predominated, but with an absence of the tubercle bacillus or only an occasional one after many fields had been scrutinized, all controlled by a positive albumin content.

Case 1.—Miss F., aged 24, came under my care Feb. 14, 1912, a fairly well-developed girl, general appearance good, complaining of a slight pain in the back and a tired feeling, giving the following family history: Father aged 61 in good health, mother aged 60, well. Three sisters and one brother living and well. One brother died four years ago at the age of 30 from stomach disease and another died ten years ago at the age of 19 from some pulmonary disease, very probably tuberculosis. The patient states that she has never been sick excepting in childhood at the age of 3 when she had a severe attack of whooping-cough. As stated above, the patient's appearance was good, fairly well-nourished, skin normal, no cachexia. Physical examination on percussion gave a slightly higher note in the interscapular region to the left of the spine extending upward toward the left apex; over this area the resonance was slightly impaired and the whispering voice somewhat intensified; anteriorly above and below the clavicle the note was also somewhat higher; no râles, pulse 94, temperature 98.8, time 4 p. m. left pupil dilated; systolic blood-pressure, sitting, 100.

Diagnosis: Incipient pulmonary tuberculosis. Sputum Examination: In looking over many fields an occasional tubercle bacillus was found, but of all the most characteristic feature was the pronounced lymphocytic picture. Every separate field was full of the small mononuclears averaging about 90 per cent. of the total cellular element, and in addition by chemical examination the sputum was found to be massively albuminous. Patient succumbed in January, 1914, from generalized tuberculosis.

Case 2.—Mrs. McC. Physical examination warranted a diagnosis of pulmonary tuberculosis first stage and examination of the sputum elicited the following facts: Owing to the tenacious consistency of the sputum, it was necessary to mix it with an equal amount of distilled water, and from this diluted expectorated material, smears were prepared. All these smears when stained gave a most distinctly lymphocytic picture, the small mononuclears being everywhere greatly in excess. In looking over each field very carefully, no tubercle bacilli were observed, when in the tenth field a single bacillus, morphologically and tinctorially, was seen. Now by actual count 250 more fields were most carefully scrutinized, but not another single bacillus could be demonstrated, and besides the preponderance of small mononuclear lymphocytes, the sputum was found to be massively albuminous. I now began to entertain some doubt if I had really seen a bacillus. Might not that have been an artifact? To satisfy myself on that point, I submitted some of the sputa to the antiformin method of examination. To 10 c.c. of the diluted sputum, I added drop by drop pure antiformin until a clear solution was obtained; then 8 c.c. of 95 per cent. alcohol were added and the whole centrifuged and from this sediment a smear was prepared in which I found five distinct groups of bacilli with from four to six bacilli in each group.

Case 3.—Mr. W., formerly of this city but now residing in California, consulted me, June 25, 1912. Patient was in fairly good health doing an office business and at his desk every day. He had a slight hacking cough of about a month's duration and he requested that an examination be made and that a prescription be given to stop the cough. Pulse was 86, temperature 98. Physical examination gave slight evidence of a bronchitis. The sputum examination did not show a single bacillus in a careful scrutiny of innumerable fields, but everywhere there was a distinct lymphocytosis of the small mononuclears, besides moderate amount of albumin. Eight days after I injected 1 mg. Koch's tuberculin O. T. intracutaneously, which was followed by a most positive reaction. A sputum examination made from expectoration secured two days after this positive finding gave the same lymphocytic picture as in the sputum examined ten days before, with the same moderate amount of albumin; but in addition many tubercle bacilli, chiefly in groups, were demonstrable.

Case 4.—Miss V., aged 19, living out of town, first consulted me March 21, 1914. Physical examination permitted the diagnosis of pulmonary tuberculosis, slightly past incipiency. At that time the clinical picture was at variance with the physical findings, the patient being apparently a very well-nourished girl, but now the case is very active. At the first visit the sputum examination showed a most distinct predominance of the small mononuclears and in addition a moderate amount of albumin. This in itself was so pronounced and positive that the sputum was labeled as that obtained from a positively tuberculous person. After long and careful search I was finally rewarded by finding a single bacillus. By the antiformin method, I was able to demonstrate positively the presence of the tubercle bacillus; six were found in all, four singly and two in a group.

Case 5.—Miss M., nurse, aged 32, came first under my care in June, 1913. There were no cough, no pain and no loss in weight, only a little tired feeling. Pulse was 88, temperature 98.4. Physical Examination: Apex, right, posterior muscle spasm, harsh breath sounds, some sonorous râles; anteriorly right, fremitus distinctly increased, prolonged expiration, harsh breathing and a few fine inspiratory râles. A dry pleurisy developed which under immobilization of the chest wall with adhesive straps gradually subsided. Diagnosis: Incipient pulmonary tuberculosis with a secondary pleurisy. Sputum examinations at that time gave the following findings: Not a single bacillus could be found after examination of a countless number of fields, but a distinctively lymphocytic picture was everywhere plainly noticeable, and besides a moderate amount of albumin was present.

The parallelism between the lymphocytic sputum picture on the one hand, and the positive albumin content of the expectorations on the other, was so evident in all of these histories, and in nearly every one of the above-conducted chemical and microscopic examinations, that a fairly positive diagnosis of pulmonary tuberculosis could truthfully be made on these findings alone.

On the remaining sputum examinations, 55 in all, which were bacilli negative, the following observations were made: Seventeen did not show tubercle bacilli, albumin or lymphocytosis; consequently they were all labeled as sputum samples secured from positively non-tuberculous persons. In 36 of the remaining 38 specimens, a negative bacillus finding was recorded; of 2 no record can be found. In 4 of this series the sputum was too bloody to warrant an albumin test; in 7 others the albumin content was not recorded; the remaining all showed albumin in variable amounts, and as to the cellular constituents of the sputum of the last series, I can state that in 14 the lymphocytic picture was not clearly studied or accurately noted, in 5 a distinct leukocytosis prevailed, and the remaining showed no preponderance of either small or large lymphocytes or of leukocytes.

From these observations and studies made both chemically and microscopically on 199 samples of sputum secured from suspected tuberculous persons, it is reasonable to permit a justification of the following conclusions:

1. A sputum lymphocytosis showing under the microscope 50 per cent. or more of the small mononuclear leukocytes (lymphocytes) with a moderate amount of albumin by chemical test speaks very strongly for the presence of a pulmonary tuberculosis.

2. In preincipient or incipient cases of pulmonary tuberculosis a lymphocytic sputum is usually present with a greater or lesser albumin content; in this the tubercle bacillus may be entirely absent or only an occasional bacillus found.

3. The presence of the mononuclear lymphocyte in sputum in preponderant amounts and a positive albumin test, is simply the forerunner or near the beginning of positive findings, for the tubercle bacillus if not already present in the expectorations will soon be found.

4. In a sputum giving a lymphocytic picture in the absence of tubercle bacilli, a positive albumin content has been demonstrated; this is confirmatory evidence that the sputum is that from a person suffering from pulmonary tuberculosis, and hence:

A careful microscopic study of every sample of sputum under examination should first be made for either the presence or absence of the tubercle bacillus; if this is negative and with a preponderance of the small mononuclear leukocytes in every field with a positive albumin finding by chemical test, in moderate amount, we are justified in assuming that the source of this expectoration is that found in a positively tuberculous individual.

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MYIASIS OF THE URINARY PASSAGES

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WASHINGTON, D. C.

Myiasis is the general term applied to the occurrence of dipterous larvae in man. Though the larvae of many flies have been found, those most common are from the *Fannia scalaris*, the small fly frequently seen in the spring darting actively about under chandeliers or other pendent objects. A common name for it is "latrine fly," from its favorite resort.

This fly lays its eggs in dark, moist places, and the larvae may appear in from one to eighteen hours, depending on the warmth of the place of deposit. The larvae are full grown within from six to twelve days, but under favorable conditions, three or four weeks may elapse before they enter the pupal stage.

The literature on the subject is limited. Osler's "Practice" devotes a page to the general subject of myiasis, but does not mention its occurrence in the urinary passages. Stiles in Osler and McCrae's "System of Modern Medicine" gives up a few lines to the general subject only. The Library of the Surgeon General's Office furnishes but few titles.

Captain P. S. Lelean[1] collected a series of thirty cases. The earliest one was reported by Ambroise Paré in 1582. In most of these cases the larvae were believed to be those of the *Fannia scalaris* (formerly *Homalomyia*). He relates one remarkable case of myiasis externa. In 1842 an eminent London physician wrote as follows:

> I saw hundreds of worms escaping from the skin. The carpet was covered with them where she stood dressing. They had the power of ejecting themselves to a distance of from 12 to 20 inches.

1. Lelean, P. S.: Brit. Med. Jour., 1914, i, 245.

In 1899 Lieutenant-Colonel Smith saw a dipterous larva spring 3 feet. The saltatory powers of the cheese skipper will be recalled.

Cipriani[2] reports the case of a woman vagrant, badly constipated, who passed dipterous larvae in quantities from the vagina. A rectovaginal fistula existed. Cipriani believed that the eggs had been deposited on food and hatched in the lower bowel. The hard fecal masses in the rectum had aided the larvae in producing an ulcer which had perforated the rectovaginal septum, allowing the passage of the larvae into the vagina.

Réné Chevrel[3] makes a careful analysis of all reported cases of myiasis of the urinary passages, and adds a case of his own. He concludes that only twenty such cases have been reported, six of which he regards as authentic, ten probable and four doubtful. His own case makes seven which are authentic.

He is of the opinion that while dipterous ova may be carried into the urinary passages by sounds or catheters, or in water used for irrigating, they generally are deposited about the meatus urinarius where are found the conditions favoring their growth, namely, darkness, moisture, warmth, oxygen and food, which last is furnished by a gonorrheal or other albuminoid discharge. The eggs hatch promptly and the young larvae pass into the urethra and on into the bladder in search of food. They require but little oxygen, and in the experiments carried out by Chevrel were kept under water for hours, becoming active when taken out. There is always some air in the urethra and probably in the bladder.

The contamination is favored by sleeping without cover in hot weather, flies having free access to the genitals and anal region. Women, wearing longer gowns than men, are less affected. On the other hand, women and children without proper underclothing are more liable to infection.

Chevrel's case was that of a paralytic of 55, wife of a farmer, who was left alone all day on a chair which had been converted into a commode by removing the seat and winding the framework with rags, the receptacle for the dejecta being placed on the floor and the flies being free to swarm at will about the buttocks. She passed larvae with the urine, daily, from May 19 into July.

REPORT OF AUTHOR'S CASE

Oct. 29, 1914, H. P., man, aged 32, living on a small farm in Virginia, who had been attending my service at Emergency Hospital, brought to my office an object that he had passed with the urine, which was later identified as a larva of *Fannia scalaris*. He had voided similar objects with the urine October 19 and 28, but had not brought them to me thinking that I would laugh at him.

This man had a chronic posterior urethritis and for some months had been in the habit of urinating in a glass when at home. This glass he kept in the shed at the rear of his house, turned upside down on a shelf, and it was always rinsed after using. He had been using a small syringe of hard rubber for urethral injections and had kept this wrapped in paper and in a closed drawer, so that, apparently, the larvae could not have been in the glass, nor the eggs or larvae in the syringe.

About 8 o'clock in the morning, while digging potatoes in his garden, he was seized with an intense desire to urinate, hurried to the shed, felt something pass with the urine and found the larva in the glass. He saw no motion. I received it two hours later and it was in a perfectly fresh condition.

2. Cipriani: Il Morgagni, 1902, xliv, 384.
3. Chevrel, Réné: Arch. de parasitol., 1909, No. 3.

He has seen no larvae since nor was he able to find any in the feces after diligent search.

Contamination probably took place while seated long at stool, the flies being attracted by the presence of a slight urethral discharge. That larvae were voided ten days apart would indicate that they were from different infections. The larvae had evidently penetrated the prostatic urethra, judging by the patient's sensations, though the cystoscopic findings were negative.

I believe that the patient's word may be relied on and that this may be considered the eighth authentic case of myiasis of the urinary passages.

I am indebted to Dr. L. O. Howard, entomologist of the U. S. Department of Agriculture, for the identification of the specimen and for the copy of Chevrel's article.

223 Bond Building.

ADRENAL PRECOCITY

PRECOCIOUS DEVELOPMENT OF THE EXTERNAL GENITALS DUE TO HYPERNEPHROMA OF THE ADRENAL CORTEX

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COLUMBUS, OHIO

The case to be reported presents one of those rare conditions of childhood in which with the precocious appearance of hair on the face and pubes, and the equally precocious development of external genitals, there appears an abdominal tumor due to the growth of a hypernephroma of one adrenal body.

In an exhaustive article on this subject, with the report of one case, Jump, Beates and Babcock[1] have collected from the literature records of seventeen cases, their own case making the eighteenth. In all the cases the conditions present were verified by a more or less complete necropsy. Other cases they find reported, but without necropsy, so that the diagnosis is in doubt. In one case necropsy showed both adrenals apparently normal, but the necropsy was brief, and the examination evidently superficial. Of the eighteen cases reported, fourteen were girls and four boys. In all there was an overgrowth of hair on the pubes, in fourteen an overgrowth on the face and in five in the axilla. There was overgrowth of the body, due to fat or muscular development, in all; facial acne with rough skin in some; precocious menstruation and development of the breasts in only one. Pigmentation of the skin was present in many, but in none anything like Addison's disease. Some showed mental precocity, but the majority were dull. There was a tendency in all to the development of the male characteristics at the expense of the female in the girls, and an intensification of the male characteristics in the boys. In all of the cases the tumor was found to involve the adrenal cortex, and in no case was a tumor of the medulla alone found associated with this precocious development.

As showing the peculiar change in sexual development, one case is referred to of a girl of 16 whose menstruation began when she was 15 years old and ceased after one year. At this time she had developed a mustache and beard, and hair on her thorax. She became fat and her voice became masculine.

Of the eighteen cases reported, all patients died before they were 16 years old. Some were operated on and died shortly after. In others the growth was inoperable when the patient came under observation. Because of the hopeless character of the disease without intervention, the authors properly advise exploratory operation in the early stages of the development of the disease, hoping that the removal of the adrenal at an early stage might result in a cure.

REPORT OF CASE

T. R. F., boy, aged 5 years and 10 months, was referred to me July 6, 1914, by Dr. E. A. Moore, the family physician. In his letter arranging for the consultation the doctor referred to the precocious sexual development and to the presence of an abdominal tumor, the removal of which was desired. In reply to the letter I suggested that the case belonged to the rare class described in the journal referred to, and that it would probably be found inoperable. A few days later the patient came in, accompanied by his father and an uncle, Dr. N. F. Mason of Columbus. He was rather underdeveloped when born. The father thought the sexual development commenced when he was about 18 months old. He commenced to talk and walk at 9 months, and at 10 months he could talk well and "run like a partridge." After that his mental development ceased to keep pace with his physical. When he was 3 years old there was hair on the pubes and face, and he had a voice like a man, according to Dr. Mason. He was active and vigorous, and was quite useful in running errands. Probably in December, 1913, it was noticed that his abdomen was getting larger, and this enlargement continued and became quite rapid. The surface of the body became roughened, and covered more or less with sores, particularly on the chest and back, and acne developed on the face. The patient in height and weight was about normal for his years. The facial expression, however, seemed to be that of a man of 35 or 40. He had been shaving for some time. The face was badly marked with acne. There were great crusts over the upper chest and back. The chest looked very much as though it had been burned by Roentgen rays. The genital organs were apparently those of an adult, except that the testicles were small and not completely descended.

There was a large tumor in the abdomen, this being most pronounced on the left side. It was extensively adherent, and somewhat nodular. There seemed to be a second mass over toward the right, but no connection between the two could be determined. The legs were decidedly bowed, but this the father attributed to his walking so early. The child could utter some words, the voice being that of an adult, but he was mentally a mere child.

As the tumor was large and extensively adherent, and the child's general condition poor, it was evident that no operation should be considered and the child was sent home. While he was under my observation the urine was obtained, which was normal, though containing a faint trace of albumin. Blood-examination revealed; hemoglobin, 85 per cent.; red cells, 4,480,000; leukocytes, 14,000; polynuclears, 81 per cent.; small lymphocytes, 13.6 per cent.; large lymphocytes, 5.4 per cent.

The child's general condition remained about the same after his return home, but with gradual failure, and he died the morning of August 29. The necropsy was made by Drs. E. R. Shilling, pathologist to Grant Hospital, and H. M. Brundage, pathologist to Mt. Carmel Hospital, who reported as follows:

"Height 42 inches; chest measurement 24 inches, waist measurement 32 inches. Facial expression of a man of 40. Penis 4 inches long, with marked development of pubic hair. Testicles in the canal. Feet and legs enlarged. Linea albicantia distributed over the abdomen and around the ankles. The brain was removed, and appeared normal in every way. Pituitary body appeared normal, and was

1. Jump, H. D.; Beates, Henry, Jr., and Babcock, W. W.: Precocious Development of the External Genitals Due to Hypernephroma of the Adrenal Cortex, Am. Jour. Med. Sc., 1914, cxlvii, 568.

removed for sections. Thyroid and parathyroids small but otherwise normal; were saved for sections. In the abdomen was a large tumor, lying between the layers of the mesentery of the descending colon. On removal could peel the kidney out of its capsule and easily traced its vessels and the ureter along the capsule of the tumor. The kidney was evidently normal and functionating. The tumor weighed about 15 pounds, and measured 12½ by 9 inches with numerous small nodules protruding. On section the mass was very soft, well marked off into medulla and cortex, its origin evidently the left suprarenal gland. Right kidney normal, but its suprarenal gland was about the size of a walnut, red and friable. The liver was full of metastatic nodules. Other organs of the abdomen negative. The lungs contained numerous metastatic nodules. Other organs of the chest normal. Pieces of the tumor were removed for section."

Microscopic examination of the tissues by Drs. Coons, Shilling and Brundage showed the pituitary body and the pineal gland to be normal; also the thyroids and parathyroids. The kidney showed a chronic diffuse parenchymatous nephritis. The testicles were normal for a boy of his age. The large abdominal tumor was typical of rapidly growing hypernephroma, involving the adrenal cortex. The right adrenal showed a beginning hypernephroma similar to the left.

A SIMPLIFIED METHOD FOR THE INTRAMENINGEAL INJECTION OF NEOSALVARSAN IN SYPHILIS OF THE NERVOUS SYSTEM *

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Since Swift and Ellis[1] published the technic and the results of their method of introducing salvarsanized serum into the subdural lumbar spaces, there have been a number of reports from those using the original method and several modifications of the method, notably by McCaskey,[2] Fordyce[3] and Pilsbury.[4] There is no question that the technic is elaborate, not altogether free from danger (Lorenz[5]) and it gives no idea of the amount of salvarsan used. It is not known also what the combination of salvarsan and serum is which is injected.

Swift and Ellis found neosalvarsan solutions less irritating to monkeys when given subdurally. We found the same relation between the two drugs in dogs and in rabbits. Salvarsan, first used by us in very dilute solution, has been put aside for neosalvarsan, which seems far preferable for intrameningeal use.

Ravaut[6] gives neosalvarsan in hypertonic solution. He uses 0.3 gm. in 5 c.c. distilled water, which gives a solution such that 1 drop equals 1 minim. Of this he gives from 3 to 12 drops by means of a special syringe, diluting it with spinal fluid. This seems an unnecessary waste of a rather expensive drug, especially if only one injection is to be given. Wile,[7] in this country, has used Ravaut's technic with some success.

After a year's experience with the method about to be described, I feel justified in presenting it and recommending it. Ravaut's work was unknown to me until several months after we had used the method at the Milwaukee County Hospital and in private cases. In my hands the method has been most satisfactory, and, I believe, fulfils the requirements for simplicity and rationality of procedure. The patients, especially tabetics, often have an exacerbation of pains in the legs or of girdle pains, but these pass off over night, only rarely necessitating a hypodermic of morphin.

There can be no doubt that in order to render the maximum service to patients, treatment must not be so complicated that only a few exceptionally trained men in conjunction with well-equipped laboratories can administer it. It must ever be our aim to simplify therapeutic procedures so that many will be able to benefit thereby. The point in the treatment of cerebrospinal syphilis is to get the spirillicide drug to the infecting agent in the spinal cord and brain with the least harm to the patient but the greatest harm to the parasite.

It has always been our custom to inject neosalvarsan intravenously and intrameningeally at the same sitting. We have never given the latter alone except in one case of negatively reacting tabes in order to control the lightning pains.

TECHNIC

We require freshly sterilized 0.5 per cent. saline solution made from freshly distilled water; a sterile 25-c.c. glass-stoppered cylinder; a sterile 1-c.c. pipet and 10-c.c. pipet graduated in 0.1 c.c.; two sterile medicine glasses; a 20-c.c. sterile Luer syringe, with needle; a 10-c.c. Record syringe, sterile; a spinal puncture needle with stylet into which the end of the Record syringe fits, sterile; some form of arm constrictor, sterile sponges, towels, alcohol and iodin.

Nine-tenths gm. neosalvarsan is dissolved in 18 c.c. of the saline solution. One c.c. of this equals 0.05 gm. One c.c. of this to 9 c.c. saline is Solution 2. Four c.c. of Solution 2 to 6 c.c. saline is Solution 3. One c.c. of this contains 2 mg. of neosalvarsan. With all the materials and glassware ready these solutions may be prepared at the bedside.

With the 20-c.c. syringe the 17 c.c. neosalvarsan is given intravenously. The patient is then turned over on his side. Before the spinal needle is introduced 1, 2 or 3 c.c. of Solution 3 is drawn into the Record syringe. I usually do not give more than 2 c.c. or 4 mg. The spinal puncture is then made and as soon as the fluid is flowing freely the syringe containing the neosalvarsan is fitted to the head of the needle and gentle suction made until the syringe is full of spinal fluid. After holding a brief time the whole is *very* slowly and at the least amount of pressure injected into the meninges through the needle *in situ*.

(Note: Should more than 4 mg. be used the dilution can be made stronger as required, although 6 mg. has been my maximum dose and from 2 to 4 mg. the usual dose.)

ADVANTAGES

We claim for this method: (1) maximum of safety; there is no increase in pressure, no introduction of a large amount of foreign material, no shock from differences in temperature of the spinal fluid and the solution injected; (2) absolute control of dosage.

Several times a blood-vessel has been struck and the spinal fluid has been quite red in color. The injection of this blood-stained fluid has not resulted in one particle of harm as far as we could determine.

Injections are given one to two weeks apart, and the results and number of injections are controlled by serobiologic reactions of blood and spinal fluid.

141 Wisconsin Street.

* From the Medical Clinic of the Milwaukee County Hospital.

1. Swift, H. M., and Ellis, A. W. M.: New York Med. Jour., 1912, xcvi, 53; The Treatment of Syphilitic Affections of the Central Nervous System with Especial Reference to the Use of Intraspinous Injections, Arch. Int. Med., September, 1913, p. 331.
2. McCaskey, G. W.: The Autoserosalvarsan Treatment of Syphilis of the Central Nervous System, THE JOURNAL A. M. A., May 30, 1914, p. 1709.
3. Fordyce, J.: The Treatment of Syphilis of the Nervous System, THE JOURNAL A. M. A., Aug. 15, 1914, p. 552.
4. Pilsbury, L. B.: Paresis Patients Treated with Intraspinal Injections of Salvarsanized Serum, THE JOURNAL A. M. A., Oct. 10, 1914, p. 1274.
5. Lorenz, W. F.: Wisconsin Med. Jour., 1913, xii, 171.
6. Ravaut: Quoted by Wile (Footnote 7).
7. Wile, Udo J.: The Technic of the Intradural Injections of Neosalvarsan in Syphilis of the Nervous System, THE JOURNAL A. M. A., April 11, 1914, p. 1165.

A CASE OF ULCERATIVE PNEUMOCOCCUS ENTERITIS WITH PERITONITIS FOLLOWING LOBAR PNEUMONIA

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The following case is reported as being of interest because of the comparative rarity of the condition, the interesting operative findings and the recovery of the patient.

History.—S. P. T., a mulatto laborer of good habits, aged 56, was seen first, March 3, 1910. He had had typhoid fever in his teens; an operation for hemorrhoids at 30, and for ten or twelve years preceding the present illness, more or less "stomach trouble" aggravated by chewing tobacco, and characterized by gas, soreness in the pit of the stomach and attacks of pain under the right lower ribs extending through, beneath the right shoulder blade and to the right shoulder. These attacks were usually accompanied by huge hives. The patient had been feeling poorly all the fall and coughed a little. Family history as far as patient knew was negative as to tuberculosis.

Present Illness.—February 10, following exposure and chilling, patient had typical attack of lobar pneumonia involving the right lung; crisis occurred on the ninth day; since then he has coughed moderately and raised a fair amount of purulent sputum but has not gained any strength and has constant distress in his stomach with tenderness over the upper abdomen; bowels have not moved for two days.

Physical Examination.—Temperature 97.6, pulse 72, slightly irregular and rather poor quality; respirations 19. Patient moderately emaciated, sweating profusely, conjunctivae subicteric; tongue heavy yellowish coat, breath foul; chest shows slight dulness, increased vocal fremitus and bronchovesicular breathing over lower lobe of right lung; abdomen slightly below level of ribs; extreme tenderness in upper abdomen, especially in epigastrium to the right of midline, right hypochondrium and just above and to left of umbilicus.

Sputum examination showed only many pneumococci and pus cells, no tubercle bacilli. Leukocytes 9,800.

Urine examination was negative.

Treatment and Course.—Calomel, ¼ grain every hour for five doses, to be followed by a saline, was ordered and a liquid diet.

March 4, temperature was between 97.6 and 98.8, pulse between 78 and 85; bowels moved freely and patient vomited a large quantity of dark green bile. There was less pain and tenderness but increased weakness.

March 5, temperature 98.4; pulse 76, tongue clean, breath no longer foul; patient felt better.

March 6, temperature 99.3, pulse 88, respirations 20. Patient complained of great pain and tenderness in gall-bladder region, slight hiccup and mild distress in urinating. Three large herpes appeared on the lips. Abdominal examination showed tenderness as in first examination; urine showed neither albumin nor casts. Leukocytes 10,600. One brown liquid stool was obtained by enema.

March 7 and 8 there was no material change except for cessation of hiccup and less pain and tenderness. Herpes appeared on lips, border of tongue and pharynx. Bowels moved by enema; small brown, soft stool, some mucus.

March 9, patient much worse; vomited some dark blood, passed several black tarry stools; microscopic examination of stool showed an enormous number of pneumococci. Examination of patient showed temperature 98, pulse 104, respirations 22, peritonitic facies, scaphoid abdomen, with rigidity, especially in upper abdomen above umbilicus. Leukocytes 18,000, 75 per cent. of polymorphonuclears. Patient was removed to hospital and laparotomy under light ether anesthesia was done by Dr. L. W. Toles late in the afternoon, at which time patient's condition was poor. Pulse 120, temperature 98.4 and abdomen slightly distended.

Operative Findings.—The abdomen was opened by an incision in the gall-bladder region parallel and to the right of the median line, and the peritoneal cavity was found to contain a fairly large amount of thin pink-tinged fluid with a few fibrin flakes. Stomach was normal; gall-bladder small, dark and shriveled; liver very small and apparently atrophic. The small intestine throughout its entire length was thickened, intensely congested, almost hemorrhagic and the seat of numerous small acute ulcers showing as more deeply congested spots softer than the surrounding areas. These ulcers were most numerous in the upper part of the jejunum and decreased in number in the ileum, especially the lower portion. In a somewhat hasty examination no perforation was found and no ulcers were seen in the large intestine. Appendectomy was done, the abdomen closed and the patient left the table in very poor condition. Pulse 120 and of poor quality. Strychnin, 1/30 grain, was administered hypodermically, and normal saline was given on the table.

Postoperative History.—Eight ounces more of saline were given by rectum and strychnin, 1/60 grain hypodermically, as soon as patient returned from operating room. For the first four days patient's condition was very poor, hiccup being severe and almost continuous; from three to four black tarry stools daily; pulse from 100 to 116, temperature from 97 to 100; more herpes appeared in the mouth and in the alae nasi and lobes of the ears. Those on the tongue were particularly distressing.

March 13, six days after operation, right ear ached slightly for an hour, at the end of which time, discharge appeared. Cultures from this gave pure growth of pneumococci. Hiccup stopped on the fifth day after operation, melena after the eighth, and patient was discharged March 26, the seventeenth day, but was in bed at home for ten days longer, during which he complained of pain and tenderness in the wrists and ankles. The herpetic vesicles along the tongue developed into shallow ulcers, which were extremely painful and did not clear up for several weeks longer.

Three months later patient had regained his normal weight, 150 pounds, and was able to go to work.

The condition was not correctly diagnosed prior to operation. The history suggestive of gall-stones and chronic cholecystitis made an acute cholecystitis of pneumococcus origin seem probable, but with the appearance of melena, duodenal ulcer had to be considered. The peritonitis could have been a consequence of either, and therefore gave no aid to diagnosis. Not enough importance, it is probable, was attached to the rather profuse appearance of fresh herpes during the early days of the illness. Also since the gastrointestinal complications and sequelae of lobar pneumonia have received rather scant attention in description of that disease, the possibility of pneumococcus enteritis did not occur to the observers.

AN UNUSUAL CASE OF SCREW-WORMS IN THE NOSE AND NASAL ACCESSORY SINUSES

GEORGE U. HUBER, M.D., AND FRANK L. FLACK, M.D., COFFEYVILLE, KAN.

J. M., farmer, aged 66, was referred to us Oct. 5, 1914, for hemorrhage of the nose. This patient had had trouble with his nose for several years. One year ago last August his nose began to discharge and became very sore. About this time a traveling medicine man came through his part of the country selling an inhalation powder for treatment of diseases of the nose. He purchased a large amount of this medicine for use and to be doubly certain of a cure traveled with the medicine man for several months and took treatment under his directions.

At varying intervals large masses of necrotic material were discharged from his nose. Following this he was relieved. Up until two weeks ago his condition had remained about the same. At this time a fly went in one nostril and came out of the other. Following this trouble he became rapidly worse. October 2, he felt something moving in his nose and called a regular doctor who saw him several times and gave him treatment. This was of but little benefit. Finally the doctor injected chloroform and removed seventy-two Texas screw-

worms. The patient's condition remained serious and he was brought to the hospital for treatment. At this time a Wassermann test was made which was strongly positive.

Under general anesthesia the following conditions were discovered: The walls of the right antrum of Highmore were completely necrosed and the antrum filled with worms. The middle turbinate on the right side was markedly necrosed. The right frontal sinus was open, and the right ethmoidal cells exposed. The walls of the antrum on the left side were partly necrosed. The turbinate on this side was partly necrosed and the ethmoidal cells exposed. The right eye was swollen shut and a worm was found in the lacrimal sac. These worms were the ordinary Texas screw-worms measuring about 1 inch in length and about ¼ inch in diameter. Forty were removed at operation. On the right antrum a Cadwell-Luc operation was performed. On the left antrum a Denker operation was done. The Ballenger turbino-ethmoidectomy was performed on both sides. The right frontal sinus was curetted. The right canaliculus was split and the lacrimal duct probed. All sinuses were packed with iodoform gauze, after a thorough irrigation with a 10 per cent. solution of chloroform.

The after-treatment consisted in blowing iodoform into the nose and sinuses for one week and a vigorous course of antisyphilitic treatment. After a week the man was in a much improved condition and left the hospital.

This patient had a long-standing specific necrosis of the bones of the nose and accessory sinuses which undoubtedly attracted the fly carrying the larvae and furnished favorable conditions for their growth and reproduction.

Oct. 27, 1914, the patient was cured of the worms, and the nose looks perfectly healthy except for the damage done by the specific necrosis previously.

OIDIOMYCOSIS IN PORTO RICO

E. R. HILDRETH, M.D., AND A. C. SUTTON, SAN JUAN, P. R.

While about 150 cases of oidiomycosis have been recorded, we think this is the first case noted in Porto Rico. The diagnosis was made from an examination of fresh specimens of pus in 10 per cent. sodium hydroxid solution, and of stained smears. The pus, which was rather whitish, contained numerous doubly-contoured, oval and spherical bodies, frequently budding, and in the sodium hydroxid solution highly refractive. They varied from 10 to 15 microns in diameter. Besides there were many smaller spherical bodies about 3 microns in diameter.

History.—Mr. D. A., aged 40, a native of San Juan, Porto Rico, who had never been off the island, was first seen in our clinic at the Presbyterian Hospital, San Juan, July 22, 1914. He complained of painful lumps on his legs, and also cough and pain in his chest. Statements regarding any family history were unreliable.

Present Illness.—The first nodule appeared about the middle of May, on the outer part of the left leg, about 4 inches below the knee. About one month later two more appeared, one on the front of each thigh about 3 inches above the knee. Two weeks later two more came out; one on each leg 3 inches above the last ones. They began as small, hard lumps under the skin, and became steadily larger, until about an inch in diameter, when they softened in the center. They were always extremely painful from the start. The patient had had attacks of pain in his chest every two or three months for the past two or three years, accompanied by a cough with a slight amount of tenacious phlegm.

Physical Examination.—The oldest nodule was an inch and a half in diameter. The center showed distinct fluctuation. The outer edge was very hard and the surrounding tissues were somewhat infiltrated. The skin over all of them was a deep purple. The lesion just above the largest one had likewise begun to soften. The others were simply hard, painful, subcutaneous nodules. The inguinal glands on both sides were distinctly palpable.

There were no marked physical signs in the chest. There was, however, slight dulness at the left base, accompanied by a louder respiration and more prolonged and higher pitched expiration than at the right base. The sputum was never examined because the expectoration ceased before the second visit.

Treatment.—The nodules which showed fluctuation were incised and drained with iodoform gauze. By the next visit they had become deep, punched-out ulcers, which were then kept on a wet mercuric chlorid dressing. Ichthyol ointment was used to rub on the other nodules. The patient was given potassium iodid internally, 10 drops three times a day, increasing 1 drop each dose to 20 drops of a solution of 50 gm. of potassium iodid in 50 c.c. of water.

The patient showed steady improvement. The symptoms in the chest disappeared. The nodules on the legs became smaller and smaller. All the pain disappeared. When last seen, a month and a half after the first visit, he seemed fully recovered.

New and Nonofficial Remedies

THE FOLLOWING ADDITIONAL ARTICLES HAVE BEEN ACCEPTED BY THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION. THEIR ACCEPTANCE HAS BEEN BASED LARGELY ON EVIDENCE SUPPLIED BY THE MANUFACTURER OR HIS AGENT AND IN PART ON INVESTIGATION MADE BY OR UNDER THE DIRECTION OF THE COUNCIL. CRITICISMS AND CORRECTIONS ARE ASKED FOR TO AID IN THE REVISION OF THE MATTER BEFORE PUBLICATION IN THE BOOK "NEW AND NONOFFICIAL REMEDIES."

THE COUNCIL DESIRES PHYSICIANS TO UNDERSTAND THAT THE ACCEPTANCE OF AN ARTICLE DOES NOT NECESSARILY MEAN A RECOMMENDATION, BUT THAT, SO FAR AS KNOWN, IT COMPLIES WITH THE RULES ADOPTED BY THE COUNCIL.

W. A. PUCKNER, SECRETARY.

RADIUM BROMIDE.—$RaBr_2$.—The anhydrous radium salt of hydrobromic acid.—The market supply is a mixture of radium bromide and barium bromide and is sold on the basis of its radium content.

Actions and Uses.— See Radium.

Dosage.—See Radium.

Radium Bromide, Radium Co. of America.—Radium bromide is supplied in the form of a mixture of radium bromide and barium bromide. It is sold on the basis of its radium content. All deliveries are made subject to the test of the U. S. Bureau of Standards or any reputable university or radium expert whom the buyer may designate at the time of purchase.

Manufactured by the Radium Co. of America, Sellersville, Pa.

Radium Bromide, Standard Chemical Co.—It is supplied in the form of a mixture of radium bromide and barium bromide for use in applicators, inhalatoriums, and injection solutions and is sold on the basis of its radium content.

Manufactured by the Standard Chemical Co., Pittsburgh, Pa. (The Radium Chemical Co., Pittsburgh, Pa.).

Pure anhydrous radium bromide, containing 58.6 per cent. of radium (Ra), is a white or slightly brownish crystalline substance, soluble in water.

The presence of radium can qualitatively be demonstrated by electroscopic or by photographic methods.

The quantitative determination of radium is carried out according to the method of Rutherford and Boltwood (Rutherford's "Radio-Active Substances and their Radiations").

RADIUM CARBONATE. — $RaCO_3$. — The anhydrous radium salt of carbonic acid.— The market supply is usually a mixture of radium carbonate and barium carbonate and is sold on the basis of its radium content.

Actions and Uses.— See Radium.

Dosage.—See Radium.

Non-Proprietary Preparation:

Radium Carbonate, Standard Chemical Co.—It is supplied in the form of a mixture of radium carbonate and barium carbonate for use in applicators. It is sold on the basis of its radium content.

Manufactured by the Standard Chemical Co., Pittsburgh, Pa. (Radium Chemical Co., Pittsburgh, Pa.).

Pure radium carbonate, containing 79.0 per cent. of radium (Ra), is a white or slightly brownish salt insoluble in water, decomposed by acids.

No gases are given off spontaneously from anhydrous radium carbonate by reason of the decomposing action of the radiations, as is the case with the chloride and bromide.

The presence of radium can be demonstrated qualitatively by electroscopic or by photographic methods.

The quantitative determination of radium is carried out according to the method of Rutherford and Boltwood (Rutherford's "Radio-Active Substances and their Radiations").

NON-PROPRIETARY BRANDS OF ACCEPTED ARTICLES

Arbutin, Merck.—Merck and Co., New York.

Radium Chloride, Radium Co. of America.—Radium chloride is supplied in the form of a mixture of radium chloride and barium chloride. It is sold on the basis of its radium content. All deliveries are made subject to the test of the U. S. Bureau of Standards or any reputable university or radium expert whom the buyer may designate at the time of purchase.

Manufactured by the Radium Co. of America, Sellersville, Pa.

Radium Sulphate, Radium Co. of America.—Radium sulphate is supplied in the form of a mixture of radium sulphate and barium sulphate. It is sold on the basis of its radium content. All deliveries are made subject to the test of the U. S. Bureau of Standards or any reputable university or radium expert whom the buyer may designate at the time of purchase.

Manufactured by the Radium Co. of America, Sellersville, Pa.

The following preparation has been accepted for inclusion with the appendix to New and Nonofficial Remedies:

Antiseptic Supply Co., New York.

Cupric Applicators (Copper Sulphate 20-25 per cent.).—Wooden sticks 6½ inches long, tipped with a mixture of copper sulphate, alum and potassium nitrate, containing from 20 to 25 per cent. of copper sulphate, packed in gelatin tubes. Each stick is to be used but once.

Therapeutics

PREVENTION IS GREATER THAN CURE

(*Continued from page 2229*)

XIII

CARE OF THE TEETH AND MOUTH

The importance of oral cleanliness is becoming more widely recognized. The discovery that individuals, apparently well, may be carriers of pathogenic germs, especially of the bacillus of diphtheria, of the pneumococcus and of the bacillus of influenza, makes persons so infected a menace to their associates. How frequently the pneumococcus causes pneumonia in one who carries this germ accidentally is of course not known. Whether an individual who develops pneumonia always receives an acute infection with this germ, or whether, becoming debilitated by an influenza or a cold caused by some other germs, he has his resisting power so reduced that the pneumococci present in his mouth and throat cause active infection, cannot readily be determined. Streptococci and staphylococci are of frequent occurrence in the mouth, especially when there are decayed teeth, or diseased gums, tonsils, noses or any of the sinuses surrounding these regions. Whether these germs so present in a person's mouth frequently or infrequently infect others need not be considered. It is certain that the carriers of the germs are a constant source of danger to themselves, not only on account of the local disturbance, which may become more or less permanent with more or less disorganization or disintegration of solid tissues, but also from the danger of septic and pyemic infection. From such local infections joint inflammations are frequently caused, whether or not this is the case with true rheumatism, endocardial inflammations, and possibly such serious blood disturbances as pernicious anemia or leukemia. More or less serious glandular disturbances may occur from these local putridities or suppurations and the lungs are in constant danger from infection from these organisms. Some of these bacteria may also cause conditions that allow an infection by tubercle bacilli. Chronic nephritis must also be listed as an occasional consequence of a local infection in the mouth, nose or throat.

More or less constantly these pathogenic germs must be swallowed with food, drink and saliva. Probably most of them are killed by the hydrochloric acid of the gastric juice, provided the stomach is normal. If the stomach secretions are imperfect or if there is a chronic congestion of the mucous membrane of the stomach, many of these germs doubtless pass alive into the intestine and may there be a cause of a chronic enteritis or an infection of the gall-bladder, or they may possibly disturb the pancreas, and may be the cause of an ultimate incurable organic disease or incurable blood disturbance.

The corollary of the foregoing, and the possible and more or less frequent results of mouth infection which have not been overestimated, is cleanliness of the mouth, nose and throat. The teeth and mouth should at least be thoroughly cleansed on rising in the morning and on going to bed at night. A thorough use of the tooth-brush with such tooth-powders or tooth-pastes as seem advisable, depending on the age of the person and the condition of the gums and the character of the deposits that occur on the teeth, should be made daily. Some teeth cleanse readily and do not require a very stiff brush or very harsh treatment. Others need a stiffer brush and a powder, not too soapy, for complete removal of all deposits. If the gums bleed readily, they should be hardened with simple astringent washes, either a dilute alcohol or a dilute astringent tincture such as myrrh, or a tannic acid wash. Potassium chlorate mouth-washes and gargles are very soothing to irritated mucous membranes, but ordinarily any simple alkaline wash or mildly antiseptic solution as borax or boric acid solutions will be found sufficient, with the proper rubbing of the gums with a not too hard tooth-brush, or rubbing the gums with the fingers, that is, massage. The powder selected for cleansing the teeth is generally alkaline, with chalk or magnesia, but it has been shown that acid cleansing preparations, especially the acid fruits, are more efficient in causing the death of bacteria that occur in the mouth.[1] Whatever powder is chosen, it should contain no hard crystals that could possibly injure the enamel of the teeth.

A few children have never been taught to cleanse their teeth at all; many children have never been taught the proper manner of cleansing their teeth. Consequently, it should be the duty of the trained nurses of schools not only to examine the condition of the teeth and mouth of the children, but also to instruct them how to use their tooth-brushes, and what the hygiene of the mouth means. Some physicians urge that there should be daily gargling with some simple mouth-wash or physiologic saline solution, and also urge the snuffing into the nostrils and then expelling of such solutions. Theoretically, cleansing of the nostrils from the dust and bacteria inhaled should be a daily duty. Washing the mouth and throat with some simple solution should also be daily done. Practically, however, it is difficult to enforce such advice. Also, as far as the nostrils are concerned, solutions

1. Oral Cleanliness, Therapeutics, The Journal A. M. A., Nov. 8, 1913, p. 1719.

and sprays may irritate the mucous membrane, or may remove Nature's protective mucus. For this reason it may not be advisable generally to recommend washing of the deeper parts of the nostrils with antiseptic or other solutions.

The removal of hopelessly decayed teeth and the filling of the cavities in teeth that can be preserved are essential to health. The trained nurse should discover such teeth in children and strongly advise, if not insist, that they be properly attended to. Alveolar abscesses, or other localized infection, should be treated by the physician or dentist until cured. Temporary frequent washing of all pus parts, unless the cavity is more or less closed, with hydrogen peroxid solutions, the dilution depending on the part affected, is efficient until the diseased part can be more thoroughly treated.

Pyorrhea alveolaris, very frequent in adults, very rare in children (unless the child is generally debilitated, or in children who have rickets) is a germ disease that is cured only by the most persistent and continuous treatment. Cleanliness and antiseptic washings are the means of prevention, but these rarely will cause a cure. Iodin treatment by the dentist will sometimes cure up pockets of infection. In inveterate cases vaccines, especially autogenous vaccines, have many times proved efficient. Sinus diseases are well treated only by nose and throat specialists.

Let it be urged that it is a mistake to retain too long a tooth that is causing disturbance. Many a serious condition and a great deal of jaw, and even antrum trouble has been caused by trying to preserve a tooth that is diseased at its root, or has a pocket of infection running down from the gum toward the root. A tooth that is diseased and cannot be well treated from the surface and which tends to cause serious disturbance of the fifth nerve, and especially if the pain comes in spasms, cannot be too soon removed. Dentists are often too conservative. Roentgenograms of the conditions in a jaw will often show a diseased tooth, or ill-placed teeth, which may be the cause of pain.

A few more suggestions might not be out of place.

First, the tooth-brush should not only be a good one, and not have loose bristles to cause injury or to be retained in the mouth or throat, but the brush should be deposited in an antiseptic solution. Of what value is it to cleanse the germs from the mouth and teeth and then allow them to grow in the tooth-brush to become a source of infection for following days? After using, the tooth-brush should be cleansed and placed in a test-tube or a bottle holder with alcohol or in a weak formaldehyd solution, as 1 part of liquor formaldehydi to 25 parts of water.

Second, the constant and frequent use of hydrogen peroxid solutions, which has become more or less of a fad with many persons, is a mistake. It is not good for the teeth, and not good for the gums, although it is used and should be used in septic or infected conditions, but not then for too long.

Third, the teeth and mouth should receive a great deal of care and attention during all illness, whatever that illness may be.

Fourth, before all operations which are not of the emergency type, the teeth and gums should be put into good condition by the patient's dentist. Before operation in all cases the mouth, teeth and gums should be thoroughly cleansed and cleaned with hydrogen peroxid or other antiseptic solution.

ADENOIDS; HYPERTROPHIED TONSILS; OTORRHEA; CERVICAL ADENITIS

While any one or any two of these conditions may occur without the others, they are all more or less closely associated, and the schoolteacher and the trained nurse should take note if any one of them is present in a child, and the child should then be sent to the medical inspector or medical examiner. The importance of treating hypertrophied and diseased tonsils has already been discussed. The association of mouth and throat diseases with cervical adenitis is well understood. Also the necessity for removing obstructive adenoids which hinder proper breathing and prevent the removal of dust particles and germs and the warming of the air, requires no discussion.

Adenoids not only cause and allow nasal catarrh, recurrent tonsillitis, chronic pharyngitis, and even bronchitis with perhaps, later, the development of cervical adenitis, but they may also be a cause of obstruction of the eustachian tubes and disturbance and infection of the ears. They may allow infection of the sinuses associated with the nostrils, and they may prevent the proper development of the bones of the face, the proper growth of the nose and cause that vacant, open-mouth expression, which is so perfectly characteristic of this simple but frequent condition. It is needless to urge that the earlier obstructive or hypertrophied adenoids are removed, the less likely are complications to occur and the more normal will be the growth of the bones of the face, nose and jaw.

The seriousness of discharging ears will be recognized when Dr. N. P. Stauffer's statements[2] are repeated, that, of 90,000 deaf persons in the United States according to the census of 1900, 51,000 were deaf from childhood, that 75 per cent. of deafness is caused by discharging ears, and that 75 per cent. of discharging ears is due to adenoids and hypertrophied tonsils.

With acute adenitis the child has a high temperature, and it is soon recognized that he is sick. It should be remembered that a child may have folliculitis in the nasopharynx which may give infection to others much the same as follicular tonsillitis. With chronic enlargement of the cervical glands the little patient's temperature and nutrition should be carefully studied. Also, any focus of infection in the throat should be noted.

The best management for the individual patient with an enlarged gland or glands is for the decision of the family physician. Not all enlarged cervical glands are tuberculous; not all enlarged glands should be removed. A suppurating gland, however, should never be neglected. Also, chronically enlarged cervical glands may become infected with tuberculosis, or may be the beginning of more serious glandular trouble, as Hodgkin's disease. In other words, enlarged glands should always be looked on with suspicion, and generally the parents should be advised that the child should not remain in school, but may perhaps attend an open-air or open-window school. The treatment should be decided by the family physician. It should be noted, however, that iodid surely, and arsenic perhaps, will stimulate a tuberculous process to more widespread activity. Whatever is done, it should be emphasized that a child with enlarged glands of the neck is under suspicion of ill health as long as such glands are in evidence.

(*To be continued*)

2. Stauffer, N. P.: New York Med. Jour., Oct. 10, 1914, p. 705.

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SATURDAY, DECEMBER 26, 1914

On account of the large amount of space occupied by the Index in this issue of THE JOURNAL, certain departments have been omitted entirely and others abbreviated.

THE INDEX

This issue of THE JOURNAL contains the index to the current, or sixty-third, volume of THE JOURNAL, including the current medical literature which has been listed from week to week. The Index contains references to original articles in over two hundred of the leading medical journals of the world, including those of the principal foreign countries.

The Index consists of two parts — an author and a subject index. Under "Authors" appear the names of all who have contributed articles to THE JOURNAL or to any other journal listed in the current literature department, as well as the names of those whose papers are abstracted in the medical society reports in THE JOURNAL. Under "Subjects" will be found complete references to all reading-matter in THE JOURNAL and references to the original articles in all domestic and foreign journals listed, arranged under the subject of the article with double entry when necessary and with numerous cross-references to facilitate the use of the Index. The figures in bold-faced type refer to reading-matter in THE JOURNAL.

The "Guide to Current Medical Literature," under which title the Index appears in pamphlet form,[1] contains, in addition, the titles of the articles listed, arranged chronologically and by journals, as in the Current Medical Literature Department. It is issued in separate form for convenience—to make it unnecessary to handle the bound volume of THE JOURNAL.

Just preceding the Index a list of the journals indexed during the past six months is given. Any foreign journal, except those starred, will be lent by THE JOURNAL to subscribers and members in the United States with the understanding that it will not be held over three days. Requests for journals should be addressed to the Library of the American Medical Association and six cents in stamps should be enclosed. This covers the average expense of mailing a journal. The addresses of the domestic journals are given, and these can be obtained direct from the publishers. No domestic journal will be lent, as these can be obtained direct from the publishers as easily and as quickly as from us.

1. The Guide to Current Medical Literature may be obtained from the Association office at 50 cents a copy.

PITUITARY EXTRACT AND MILK SECRETION

It cannot be denied that the secretion of milk is subject to nervous influences. Nevertheless physiologists have not yet succeeded either in producing secretion by the method suggested by experience with other secretory structures, namely, by stimulation of nerves going to the mammary glands, or in stopping a secretion in progress by section of such nerves. It is a well-established belief that the secretion and composition of the milk may be affected reflexly through the nervous system, as for example under the influence of the emotions. The action may even be reciprocal, as in the case of the pelvic organs, when the act of suckling excites tonic contractions of the uterus.

Food has some influence on the make-up of the milk; yet this factor is relatively so subordinated to others that in current speech the quality of the milk is regarded as a matter of "breed versus feed." Aside from both of these agencies, the nervous and the dietary, which may act on the mammary gland, one is impelled to ask how the flow is initiated or regulated from time to time in the individual. We approach here the question of the existence of galactagogues.

In 1910 Drs. Ott and Scott[1] of the physiologic laboratory at the Medico-Chirurgical College of Philadelphia found, in the goat, that during the early nursing period an intravenous injection of an extract of the posterior part of the hypophysis rapidly and greatly increased the secretion of milk. The infusion starts the flow in about one minute; it reaches its height (under the conditions of experiment) in four minutes, after which it rapidly falls to normal. As a concrete instance of the extent of this response we may quote one trial in which the flow of milk was 5 drops during five minutes before introduction of 5 drops of a pituitary extract by vein, and 405 drops in the same time thereafter. Extracts of other glands of internal secretion—corpus luteum, pineal body and thymus—may increase the milk flow fourfold in five minutes, whereas the pituitary product is by all means the most powerful galactagogue, increasing it a hundredfold or more. The ovary minus the corpus luteum has no effect whatever.

Soon after these observations were confirmed by Schäfer and Mackenzie[2] on other species of lactating

1. Ott, I., and Scott, J. C.: The Action of Infundibulin upon the Mammary Secretion, Proc. Soc. Exper. Biol. and Med., 1910, viii, 48.
2. Schäfer, E. A., and Mackenzie: Proc. Roy. Soc. (B), 1911, lxxxiv, 16.

animals. They found that the extract of the anterior lobe of the pituitary was inactive. Later Mackenzie[3] observed that the galactagogue substance is present in the pituitary body not only of lactating females, but also of non-lactating females and of males.

It need scarcely be remarked that such observations promptly suggested the application of the findings to cows and to lactating women. In the case of cattle the total effect of administration of pituitary extract on the total daily yield of milk has been negative.[4] The reason for this is made probable by studies of Hill and Simpson[5] at Cornell University. They observed, it is true, that the intravenous injection of pituitary extract (whole gland or posterior lobe alone) leads to an immediate secretion of milk very rich in fat. The effect, however, quickly passes off. There is a corresponding diminution in the yield of milk at the next milking period, and to some extent in the percentage of fat, so that in the twenty-four hours there is practically no increase in the total quantity of milk or of fat obtained.

Schäfer, in 1912, observed slight transitory effects from introduction of pituitary extract in a human subject. The most significant observation, however, is one recently reported by Hill and Simpson[6] in a healthy young married woman nursing her second baby, in the fifth month of lactation. Intramuscular injection of a commercial preparation equivalent to 20 mg. of the dried infundibular portion of the gland was followed, in ten minutes, by a marked increase in the amount of milk secreted. After a latent period of from twenty to thirty seconds the mother could feel the milk "coming into the breasts," and a few minutes later abdominal pains were experienced, presumably due to increased intestinal peristalsis. The milk withdrawn after injection was rich in fat, the average figure for the three experiments being 5.5 per cent. as compared with 3.4 per cent. for three days when no pituitary extract was administered. In the milk yielded twenty-four hours after injection the fat content was still somewhat above the normal. Although no quantitative estimations were made, judging from the mother's experience in nursing the child, it would appear that the quantity of milk obtainable by it on the morning after the injection was diminished.

The import of these observations must not be exaggerated. They afford no evidence of any increased production of milk. But the demonstration of a chemical influence manifested by altering the rate of secretory discharge is of itself an interesting accomplishment quite aside from any further immediate application thereof.

3. Mackenzie: Quart. Jour. Exper. Physiol., 1911, iv, 305.
4. Compare Gavin: Quart. Jour. Exper. Physiol., 1913, vi, 13.
5. Hill, R. L., and Simpson, S.: The Effect of Pituitary Extract on the Secretion of Milk in the Cow, Proc. Soc. Exper. Biol. and Med., 1914, xi, 82.
6. Hill, R. L., and Simpson, S.: The Effect of the Intramuscular Injection of Pituitary Extract on the Secretion of Milk in the Human Subject, Am. Jour. Physiol., 1914, xxxv, 361.

THE SUPRARENAL BODIES AND KIDNEY FUNCTION

Although the nature of the supply of vasomotor nerves to the kidney and the conditions which bring them into activity are fairly well known, additional factors which may control the flow of urine are far from being completely elucidated. Most writers on the physiology of the kidneys deny the existence of specific secretory nerves for these organs, although Asher and Pearce have suggested that the vagus and splanchnics are direct secretory nerves to them. There is a tendency in some quarters to postulate the occurrence of specific chemical excitants or diuretics, formed in the body and acting as do the group of stimulants now classed as hormones.

Experimenters who have busied themselves with the physiology of the renal secretion have at times been brought face to face with contradictions which they could not explain on a purely vasomotor basis, that is, by corresponding alterations in the blood-supply. In the course of an investigation in this field Cow[1] was struck by the different effects produced by perfusing the kidneys directly through the renal arteries and through the aorta. After the exclusion of possible sources of difference in the condition of the experiments, the only feasible explanation appeared to be that in the perfusions through the aorta the fluid in some way passed through the suprarenal glands before reaching the kidneys. A further examination of the anatomic possibilities showed that there exists, at any rate, a possible channel through which the products of the suprarenal bodies can reach the kidneys directly and without either dilution or oxidation in the general circulation.

There is nothing essentially unique in the demonstration of a direct vascular connection between the medullary portions of the suprarenal bodies and the kidneys. It has long been known that vessels in the neighborhood of the kidneys anastomose with vessels connected with adjacent parts. Such anatomic interrelations have been described between the vessels of the kidney, suprarenal and large intestine.[2] As the result of Cow's work it now appears that under certain conditions epinephrin in appreciable amount is poured directly into the kidneys from the suprarenal bodies and consequently produces a diminution in the flow of urine. This effect is precisely what takes place on stimulation of the splanchnic nerves which, in turn, are known to be the path by which fright or excitation of afferent nerves causes a reflex exhaustion of the epinephrin content of the suprarenal bodies.

In the light of this newer knowledge it may be possible to explain the findings of Asher and Pearce[3]

1. Cow, D.: The Suprarenal Bodies and Diuresis, Jour. Physiol., 1914, xlviii, 442.
2. Tuffier: Rev. de chir., 1890, p. 390. Quénu and Lejars: Etude sur le système circulatoire, Paris, 1894.
3. Do the Kidneys Have Secretory Nerves? Editorial, THE JOURNAL A. M. A., Dec. 6, 1913, p. 2073.

without introducing the hypothesis that the kidney has a direct secretory innervation. According to Cow we may assume that the stimulation of the splanchnics (as conducted by Asher and Pearce) produces an outflow of epinephrin from the suprarenal bodies and that some, at any rate, of this finds its way directly to the kidney, producing a diminution in the flow of urine. The novelty of this contribution consists in the implication that the suprarenal bodies may be regarded as direct regulators of urinary activity.

BACTERIOLOGIC STANDARDS FOR DRINKING WATER

About two years ago a commission was appointed by the Secretary of the Treasury following recommendations made by the United States Public Health Service to investigate the quality of drinking water furnished to travelers by common carriers. Affecting as it does all who travel, the question is one of practical importance to public health authorities. The commission was asked specifically to recommend standards of purity for drinking water supplied to the public by public carriers in interstate commerce. After devoting more than a year to a consideration and discussion of the problem, the commission has not yet arrived at a satisfactory consensus of opinion on a number of minor questions. In the meantime, however, the importance of establishing certain limiting requirements, and the fact that the commission is of one opinion on the essential points of such requirements, have made it seem desirable to incorporate its findings thus far in a progress report.[1] Recommendations contained in this report have been embodied in Interstate Quarantine Regulations in accordance with a letter of promulgation issued by the Secretary of the Treasury under date of Oct. 21, 1914. In the future common carriers will be required to furnish water for passengers in interstate traffic which will comply with the following criteria:

1. Water supplies conforming to the prescribed requirements shall be free from injurious effects on the human body and free from offensiveness to the sense of sight, taste or smell.

2. Supplies of the quality required shall be obtainable by common carriers without prohibitive expense.

3. The examinations necessary to determine whether or not a given water-supply meets the requirements shall be as few and as simple as consistent with the end in view.

The commission's report is specific in pointing out that "the recommendations here presented are limits of permissible impurity and in no sense standards of purity." They are recommended "not as the nearest approximation to purity which it is desirable to attain, but, on the contrary, as the farthest deviations from purity considered permissible in the water-supplies with which this report deals." It is also emphasized that these limits are only for application to the special case in question.

Because of the difficulty in correlating what might be regarded as objectionable physical and chemical properties of water with definite effects on the health of the user, and because of the minor sanitary importance at most of regulating this class of impurities, these questions have been left for further discussion, and the present report deals only with the more important matter of bacteriologic standards. It is furthermore recognized by the commission that strict specifications for a water which shall at all times be undoubtedly safe are justified by reason of the comparatively small quantities of water used by common carriers and the ready availability of methods of purification which permit the furnishing of a water of high bacteriologic purity without imposing an undue burden on common carriers.

The standards proposed, and which have been incorporated in the Interstate Quarantine Regulations, are briefly the following:

1. The total number of bacteria developing on standard agar plates after twenty-four hours' incubation at 37 C. (98.6 F.) shall not exceed 100 per cubic centimeter. The estimate shall be made from not less than two plates showing such numbers and distribution of colonies as to indicate that it is reliable and accurate.

2. Not more than one out of five 10 c.c. portions of any sample examined shall show the presence of organisms of the *Bacillus coli* group when tested by a specified procedure.

The formation of 5 per cent. of gas in lactose peptone broth incubated for forty-eight hours at 37 C. in the original sample, the development of acid-forming colonies on lactose litmus agar plates or of bright red colonies on Endo's medium plates prepared from the fermenting tube, and the subsequent formation of gas occupying 10 per cent. or more of the closed arm in lactose peptone broth inoculated with typical colonies from either of the foregoing plates, constitute the criteria for the presence of organisms of the *Bacillus coli* group which shall be used in interpreting the second specification.

It is further recommended that one portion of 1 c.c. and one portion of 0.1 c.c. of the sample be plated in lactose peptone broth in order to demonstrate more fully the extent of pollution in grossly polluted samples and that the culture mediums and methods used shall be in accordance with the specifications of the Committee on Standard Methods of Water Analysis of the American Public Health Association, as set forth in "Standard Methods of Water Analysis, A. P. H. A., 1912."

1. Pub. Health Rep., Nov. 6, 1914.

The reasonable character of these regulations, the feasibility of compliance on the part of the common carriers without undue expense, the degree of protection that such compliance will afford to travelers and the relative simplicity of the routine tests that are recommended are sufficient evidence of the serious thought which has been given to this important matter by the members of the commission, to whom much credit is due for this satisfactory outcome of their labors.

THE SIGNIFICANCE OF STARCH-DIGESTING ENZYME IN THE URINE

In the evolution of clinical diagnosis in recent years the attempts to find suitable chemical indications of functional disorders have been decidedly conspicuous. Now and then some test, like that involving the altered excretion of phenolsulphonephthalein by the kidneys in conditions of health or disease of these organs, finds a permanent application in practical medicine. The majority of the proposed procedures, on the other hand, represent a momentary enthusiasm on the part of some investigator. He elucidates his method with a few clinical illustrations that seem to demonstrate its utility. Presently the new test is subjected to a rigorous experimental critique and is found to be devoid of the fundamental requisite of a good test, namely, its limitation to well-defined conditions and its applicability to a restricted number of phenomena. Any reaction which fails to possess this feature of being characteristic, that is, of being exemplified by few substances at most or under a few conditions at best, loses its claim to be rated as a "test."

The urine has furnished the basis for almost innumerable attempts to devise functional tests based on chemical reactions. In some cases, as in the detection of glycosuria and albuminuria, the appearance of constituents normally absent from the urine has afforded the diagnostic reaction. In other instances, as in the study of acidosis or other metabolic disturbances, the clinical chemist has learned to ascertain the deviations of normally present urinary components like ammonia and uric acid, from their usual and readily explicable concentration. The ideal aim is to find some easily detectable or determinable substance of which the origin or physiologic history is definite. Too often the variables in the problem are so manifold that the practical solution fails.

The study of the attempts to employ the estimation of the amylolytic power of the urine as a functional test in clinical medicine well illustrates the necessity of learning the underlying facts before the use of a reaction of this sort is advised. A starch-digesting enzyme is commonly present in the urine. It is not difficult to obtain some conception of the concentration of the amylase. The latter is found, within the organism, in digestive glands and their secretions, in the blood and secretion of the kidneys. Diminution of the amylase in the urine has been described as evidence of impermeability of the kidneys. Obviously it is equally logical to conceive a lowered output of the enzyme to be due to diminished production at the various sources from which it is normally derived prior to its renal excretion; or even to an increased destruction of circulating amylase by some physiologic or pathologic agency. And accordingly one finds the urinary output of amylase related by the diagnosticians to altered pancreatic function (leading to an altered return of pancreatic amylase to the blood and thus to the urine). Indeed, from a still different point of view it has even been taken as an index of altered absorption of amylases from the digestive tract and hence as evidence of abnormal gastro-intestinal conditions.

It is not surprising, as King[1] remarks in connection with his elaborate investigation of the blood and urinary amylase conducted at the Hull Laboratory of Physiology of the University of Chicago, that amylase elimination has not been adopted more generally as a diagnostic measure either with a view to testing the functional capacity of the kidney or in order to diagnose pancreatic lesions. The physiologic conditions governing the elimination of the enzyme, as well as its actual source, have not been known definitely enough. The immediate source of the urinary amylase is the amylase present in the blood. King's experiments, as well as those of earlier investigators, show that the variations in the amount of amylase in the urine, independent of the amount in the blood, may depend on the permeability of the kidney, the condition of the renal epithelium, and on the normal physiologic variation in renal activity. It is possible that amylase may act as a stimulus resulting in its own elimination just as does urea or dextrose.

If the amount of amylase in the urine depends not only on the functional capacity of the kidneys, but likewise on the amount finding its way into the blood, how about the source of the latter? There is evidence that the salivary amylase may appear in the urine; for those animals which secrete ptyalin eliminate in the urine more amylase per kilogram of body-weight than those which do not secrete a starch-splitting enzyme into the mouth. Removal of the pancreas results in a decrease in urinary amylase, thereby suggesting that the pancreas is a direct source of amylase. Trauma of the pancreas and lesions causing obstruction to the natural outflow of the pancreatic juice lead to an increase of amylase in the urine, pointing to a direct passage of the enzyme from the gland tissue into the blood. The blood can, therefore, probably receive amylase by at least two paths, namely, directly from

1. King, C. E.: Studies on Blood and Urinary Amylase, Am. Jour. Physiol., 1914, xxxv, 301.

the glands and indirectly from the digestive tract. There are unquestionably sources of amylase other than the salivary and pancreatic glands; for even after removal of both of these there is not a complete disappearance of the urinary starch-digesting enzyme. The kidney itself may be a source; the liver, muscles, spleen and leukocytes all contain amylase and may serve as sources. Thus the increase of amylase in the blood and urine of animals dying of acute infections may be due to the greater destruction of the leukocytes accompanying the leukocytosis.

King's investigations show further not only that amylases enter the blood directly from the tissues, but also that when once in the blood the enzyme is destroyed much more slowly than is the case during its passage through the intestinal mucosa. Feeding experiments with amylase indicate that only in case the digestive tract is flooded with the enzyme does enough pass into the blood to bring about a significant increase in the urine. Aside from variations in the excretory factor, therefore, there are indications that fluctuations in the amylolytic power of the urine may be due to increased or decreased production of amylase within the body, to an obstruction to the normal outflow from the pancreas or salivary glands, to injury of the pancreas, to decreased absorption from the intestinal lumen, to the liberation of glycogenolytic enzyme, and possibly to leukocytosis. We can well agree with King's conclusion that quantitative estimations of urinary amylase alone would have but little significance as a diagnostic point. Perhaps a long series of tests coupled with an accurate history may serve as a useful supplement in the diagnosis of renal, pancreatic and obstructive lesions.

Current Comment

FLAVORS AND VITAMINS

The term "vitamin" was first applied by Funk[1] to a substance isolated from rice and occurring only in the outer portion of the grain, which is removed in polishing rice. The fact that beriberi is caused by an exclusive diet of polished rice, but may be prevented by the addition of this vitamin to such a diet, leads to the conclusion that that disease is due to the absence of this substance from the diet. Other substances have been classed as vitamins, not because of proved chemical relationship to the vitamin of beriberi, but because their presence seems to be necessary to prevent other diseases from developing. Thus Funk believes we have a vitamin of beriberi, one of scorbutus, of pellagra, etc. The discovery of the vitamins has emphasized the value of those elements of the food, which, although present in minute amounts, exercise a determining influence in the utilization of the ordinary articles of diet. The significance of this new knowledge is emphasized by Garrod[2] in his address before the British Medical Association at its recent meeting. As Garrod says, "the immense practical importance of these hitherto unknown factors is in the fact that once the missing element—the vitamine—is discovered, a specific remedy for the disease has been found." That the nutritive value of a diet does not depend wholly on its calorific value must be admitted. The importance of flavors, spices, and of the preparation of food so as to arouse the esthetic senses — in other words, the nutritive value of good cooking — has been pointed out by Sternberg[3] of Berlin, who insists that the science of cookery is not merely the application of chemistry and physics, but rather an application of the physiology of the senses, applied psychology and esthetics. The spices and flavors used by the cook, Sternberg suggests, may be closely allied to the vitamins if not identical with them. They may stand in the same relation to loss of appetite and health in general, that the specific vitamins do to particular diseases. As loss of appetite is frequently the forerunner of deficiency of nutrition, it is possible that special flavors and spices may be required for special cases and that the search for these may reward the investigator with a clearer idea of how to meet many of the indefinite ailments that elude our most precise means of diagnosis. In this connection it is worth while to note the action of harmless microorganisms in producing flavors, possibly containing vitamins. The work of Evans, Hastings, Flint and Hart[4] showed that the development of the characteristic flavor of Cheddar cheese depended on a symbiosis of organisms of various groups impossible to secure from pasteurized milk. With the use of various starters the flavor could be varied, but the process of heating the milk destroyed, in some way, the delicate interrelations of bacteria on which the characteristic flavor of the product prepared from raw milk depends. Such researches suggest unlimited possibilities in a branch of pathology which has hitherto received scant attention.

1. Funk, Casimir: Die Vitamine, Wiesbaden, 1914.
2. Garrod: Brit. Med. Jour., Aug. 1, 1914, p. 233.

THE URINARY CREATININ OUTPUT OF NORMAL WOMEN

In establishing so-called normal values for various bodily functions and likewise in relation to the chemical composition of body fluids and secretions it has been common in the past, for reasons alike of custom and of convenience, to obtain the data from healthy men. In many instances there is no obvious or inherent reason why the facts thus elicited should differ from those which might be furnished by determinations made on the other sex. For example, one would scarcely expect the composition of the circulating fluid in woman to vary essentially from that which pertains in man. The conspicuous difference in the muscular development of most women in contrast with the

3. Sternberg, W.: Arch. f. Verdauungskrankh., 1914, xx, No. 2, abstr., THE JOURNAL A. M. A., May 23, 1914, p. 1696.
4. Evans, Alice C.; Hastings, E. G., and Hart, E. B.: Bacteria Concerned in the Production of the Characteristic Flavor in Cheese of the Cheddar Type, Jour. Agric. Research, June, 1914, p. 167. Hart, E. B.; Hastings, E. G.; Flint, E. M., and Evans, Alice C.: Relation of the Action of Certain Bacteria to the Ripening of Cheese of the Cheddar Type, ibid., p. 193.

usual male type suggests the possibility that any factors involving incidents of muscular metabolism might show quantitative variations, particularly in their absolute amounts in the two sexes. That this possibility may be realized is borne out by data which have lately been submitted from the department of chemistry at the Woman's Medical College of Pennsylvania in Philadelphia.[1] Shaffer[2] considers the urinary creatinin an index of muscular catabolism and believes that sex *per se* has no influence on the excretion of this substance. The creatinin coefficient of woman will therefore be comparable to that of man provided that the muscular efficiency and the amount of adipose tissue is the same. In view of this it is interesting to note that the creatinin excretion of a group of women medical students, who might properly be considered as normal individuals, and who were on a strict creatinin-free and creatin-free diet for two days or longer, ranged from 10 to 25 mg. per kilogram of body-weight. A still more recent report of the composition of the urine of a group of women nurses in the Wesley Memorial Hospital, associated with the Northwestern University Medical School in Chicago,[3] makes it evident that the subjects studied exhibit a low creatinin excretion in comparison with the usual values found for men. There is no peculiarity in the distribution of other nitrogen factors, and no reason is apparent why there should be. Quite possibly, as has been suggested, in the case of creatinin, the fact of lower muscular development and perhaps of lower muscular tone will account for the observed findings. Shaffer has found that what he calls the creatinin coefficient, that is, milligrams of creatinin nitrogen per kilogram of body-weight, ranges from 8 to 11 for normal men. In the case of the twenty-six women referred to[1] the comparable coefficient was below 8 in all but two cases. The latter exhibited unusual muscular development and were accustomed to vigorous gymnastic work. It is probable, from the large series of data on the female sex thus made available, that individual women who through training have maintained a good muscular tone may excrete creatinin in amounts comparable with men. The fact that the average woman tends to confine herself to sedentary occupations and neglect physical exercise, so that her muscular efficiency is reduced in comparison with that of men of the same stature, will doubtless explain the relatively low output of creatinin of females.

1. Tracy, Martha, and Clark, Elizabeth E.: The Excretion of Creatinine by Normal Women, Jour. Biol. Chem., 1914, xix, 115-117.
2. Shaffer, P. A.: The Excretion of Kreatinin and Kreatin in Health and Disease, Am. Jour. Physiol., 1908, xxiii, 1-22.
3. Hull, Mary: Some Observations on the Excretion of Creatinin by Women, Jour. Am. Chem. Soc., 1914, xxxvi, 2146.

THE LESSONS OF A UNIQUE CASE OF DIABETIC ACIDOSIS

An intelligent mastery of many of the problems that arise in the practice of medicine calls for an accurate appreciation of quantitative factors. The ophthalmologist who is making adjustments of a delicate nature depends on careful measurements of certain functions of vision and parts of the eye for guidance in his procedure. Every therapeutist who administers drugs ought to have more than a superficial knowledge of their dosage. Even in matters of diet the importance of a knowledge of the fuel value of foods has begun to be recognized. It is surprising at times to note the errors which creep into applied medicine owing to ignorance of standards: in other words, to a lack of acquaintance with the quantitative features of the subject. A patient is given a quart of milk a day—scarcely 800 calories of food—and is expected to be maintained on it. Infinitesimal doses of active agents are expected to initiate heroic changes. A characteristic case is frequently shown in the treatment of acidosis in which the administration of alkali is indicated, but the quantities prescribed, though large in comparison with customary or even large doses of alkaloids or iodids or salicylates, are nevertheless sometimes almost insignificant in their relation to the acidity to be neutralized or corrected. In diabetic acidosis the quantity of the pathologically occurring acids in the urine often reaches from 15 to 20 gm. a day. It has been known to reach 150 gm., in which beta-oxybutyric acid predominates over its companion diacetic acid. These colossal amounts call for enormous quantities of alkali carbonate for their neutralization. Czapski[1] has recently described what is, as far as we are aware, one of the most extreme cases of profound acidosis ever recorded. The patient, a youth aged 16, passed through two severe periods of intense acidosis with threatening coma, at the Krankenhaus am Friedrichshain in Berlin. During the first of these, in which the beta-oxybutyric acid approached 90 gm. on each of four days, an untoward outcome was averted by intravenous injection of 100 gm. and more of sodium bicarbonate per day. In a second period, ending in death, the output of beta-oxybutyric acid and aceto-acetic acid together reached 143 gm. as a daily maximum, and persisted at about 100 gm. or more during nine days. The total output of these acids in ten days prior to the fatal outcome was more than a kilogram (1,085 gm.). More than 900 gm. of sodium bicarbonate were administered during this period without producing even a neutral reaction in the urine. These are unique data, the reliability of which is attested by the fact that they were collected in the clinic of an expert in this field of medicine, Magnus-Levy. Previous recorded cases involving an excretion of more than 100 gm. of these organic acids per day have shown a persistence of three days at best before either marked improvement or death ensued. There can be little doubt, from other facts furnished in the chemical report of Czapski, that the acids existed in part actually free in the urine; that is, there was a large deficit of bases to serve in the neutralization equilibrium. It is obvious that under such circumstances heroic doses of alkali carbonate and every available channel of introduction — by mouth, intravenously or subcutaneously — are called for. Grains of bicarbonate must be replaced by drams.

1. Czapski, L.: Beitrag zur Kenntnis und Behandlung des Coma diabeticum, Inaug. Diss., Berlin, 1913; Ein Fall extremster Acidosis im Verlauf des Diabetes mellitus, Arch. f. exper. Path. u. Pharmakol., 1914, lxxvii, 218.

NEWS OF THE WAR

In the index in this number of THE JOURNAL an increase may be noted in the number of headings devoted to war subjects. The words "war," "army," "wounded" and "wounds" are followed by numerous references occupying from three to ten times the amount of space devoted to them in previous indexes. In this issue of THE JOURNAL also appears a letter from Sir William Osler[1] which, as he states, should interest his friends both in the United States and Canada — and does this not embrace the whole profession? The views which he expresses concerning the surgical and the sanitary aspects of the war are of the highest scientific value.

Medical News

(PHYSICIANS WILL CONFER A FAVOR BY SENDING FOR THIS DEPARTMENT ITEMS OF NEWS OF MORE OR LESS GENERAL INTEREST; SUCH AS RELATE TO SOCIETY ACTIVITIES, NEW HOSPITALS, EDUCATION, PUBLIC HEALTH, ETC.)

ILLINOIS

Chicago

Personal.—Dr. Frank A. Stahl has returned after five months abroad.——Dr. George W. Mahoney was elected vice-commander and Dr. Frank P. St. Clair, surgeon, of the Veteran Corps of the Seventh Infantry, Ill., N. G., at its third annual meeting, December 19.

To Boil Water.—Health Commissioner George B. Young, on December 17, sent a warning to all persons living within the district bounded by Chicago, Belmont and Western Avenues and Lake Michigan, to boil all drinking water until further notice, on account of typhoid infection having been found in the wells of the Chicago Avenue pumping station.

INDIANA

Academy of Medicine Incorporated.—The Academy of Medicine of Logansport has been incorporated under the laws of the state, without capital stock. The directors are Drs. Rodney E. Troutman, Charles H. McCully, Henry B. Hill and others.

Personal.—Dr. George W. Brown has resigned as health officer of Frankfort on the ground of inadequate compensation.——Dr. Fred M. Towles, Indianapolis, fell on the pavement, December 2, and suffered a compound fracture of the right leg.——Dr. Thomas Ray Morrison, Churubusco, is seriously ill at Lynn, Fla., as the result of a cerebral hemorrhage.

IOWA

Small-Pox Rather than Vaccination.—In a family at Davenport a case of small-pox occurred in a son, who was removed to the isolation hospital. Vaccination of the other members of the family was advised by the health authorities. This was refused. A week later the family was placed in strict quarantine because five other members of the family developed pronounced cases of the disease.

Personal.—Dr. M. Charles Mackin has been appointed first assistant superintendent of the Clarinda State Hospital, succeeding Dr. George Donohoe, Knoxville, promoted to superintendent of the Cherokee State Hospital, succeeding Dr. Mathew N. Voldeng promoted to superintendent of the new State Epileptic Colony, Woodward.——Dr. Arthur C. Echternacht has resigned as health officer of Mason City.

Foot-and-Mouth Disease Interferes with Agricultural Courses at State College.—On account of the presence of foot-and-mouth disease in some sections of the state and the great danger of spreading it further through public meetings of farmers, Iowa State College has decided not to hold its usual short course for farmers at Ames, December 28 to January 2, this winter. Dates for extension department courses in counties now under quarantine are also to be canceled.

KENTUCKY

Epizootic Among Rabbits.—The state fish and game commission has appealed to the State Board of Health to investigate the cause of the death of many rabbits in Carlisle County. [It will be remembered that a similar outbreak has been reported from Indiana.]

Memorial Operating Room Opened.—A new operating room in memory of his father, the late Dr. Charles A. Long, was presented to the Masonic Widows' and Orphans' Home, Louisville, recently by Charles R. Long. The gift was accepted by the president of the board of directors and Dr. Ap Morgan Vance, president of the medical board of the institution.

Personal.—Dr. Joseph F. Cook, Louisville, while crossing the street, was struck by an automobile recently, suffering injuries of the head and body.——Dr. Virgil F. Barker, Newport, has returned from abroad.——Dr. William E. Gary, chief milk inspector of Louisville, was attacked and beaten by two men at his house in Avoca.——Dr. Anderson D. Park, Rockport, has been elected president of the Rockport Deposit Bank.——Dr. Charles A. Nevitt, Lexington, has returned home after an operation for appendicitis.

LOUISIANA

Personal.—Dr. Randell Hunt, Shreveport, has been elected president; Dr. H. W. Schofield, vice-president, and Dr. Louis Abramson a director of the Caddo Parish School Board.

Pesthouse Should Be Burned.—Dr. Oscar Dowling, Shreveport, president of the State Board of Health, after a personal investigation of the New Orleans Small Pox Hospital, reports that the building is unfit for human habitation and should be burned.——The city is making arrangements for the construction of an isolation hospital.

Improvements of Leprosarium.—A contract has been let for $39,560 to improve the State Leper Home at Indian Village, Iberville Parish. Under this contract the home will acquire two large new cottages, a clinical building, a powerhouse, electric light, cold storage, and a refrigerator plant and the system of sewerage, drainage and plumbing.

Rucker Testifies on Rat Proofing.—At the hearing of the case instituted to test the validity of the rat proofing ordinance of New Orleans, Assistant Surgeon-General William C. Rucker, U. S. P. H. S., gave a review of the work done by his department and detailed the state and city activities which resulted in the eradication of bubonic plague from New Orleans.

Fraternity Chapter Installed.—On December 10 the Alpha of Louisiana chapter of the Alpha Omega Alpha Medical Scholarship Society was installed at the medical department of Tulane University, New Orleans.

MINNESOTA

Follow-Up Society Organized.—The Association of Patients and Ex-Patients of the Minnesota State Sanatorium for Consumptives has recently been organized. Its purpose is to follow up all patients discharged from the sanatorium, find suitable work for the people who are recovering their health, and secure health legislation to advance the interests of the convalescents. Only persons who have been patients at the State Sanatorium, Walker, for three months or more, are eligible for membership. Dr. George William Beach, superintendent of the sanatorium, is chairman of the association and its official organ is the *Pine Knot*.

MISSOURI

Personal.—Dr. William H. Hays, Hannibal, was accidently shot in the right leg while on a hunting trip, December 3, and is under treatment at the Levering Hospital.

Club Organized.—The Physicians and Surgeons Club of Springfield was organized December 1, with an initial membership of thirty-eight. Dr. Frank B. Fuson was elected president; Dr. Joseph W. Love, vice-president, and Dr. Murray C. Stone, secretary-treasurer.

State Board of Health.—The State Board of Health held an examination at St. Louis for applicants for license to practice, December 14, 15 and 16.——The board has begun the free distribution of prophylactic typhoid vaccine manufactured at the state university under the supervision of Dr. Mazyck P. Ravenel.——The board is giving free antirabic

1. Correspondence, Medical Notes on England at War. Sir William Osler, THE JOURNAL, this issue, p. 2303.

treatment to persons bitten by animals. The serum is supplied by the United States Public Health Service and administered under the direction of the state bacteriologist at Jefferson City.

St. Louis

Memorial Meeting. — Washington University Medical School held a memorial meeting for Dr. Washington E. Fischel, a recently deceased member of the faculty. Dr. Abraham Jacobi of New York was one of the principal speakers.

Free Antitoxin.—As the result of a report of thirty new cases of diphtheria on December 2, Dr. Max C. Starkloff, health commissioner, has obtained from the comptroller an appropriation of $1,000 for the purchase of antitoxin to be used for the poor.

Visit of Dr. Vaughan.—Dr. Victor C. Vaughan, Ann Arbor, Mich., President of the American Medical Association, was the guest of the St. Louis Medical Society at its meeting on December 12, and addressed the members on "Professional Ideals." Dr. Abraham Jacobi of New York also delivered a short address.

Children's Hospital Opened.—The St. Louis Children's Hospital was thrown open for the reception of patients on December 3. On December 12, 13 and 14 the buildings were inspected by the physicians of the city. The hospital is connected with Washington University Medical Department and the Barnes Hospital.

University Dispensary Opened.—The new dispensary of the Medical School of Washington University was opened December 14. This institution has facilities for the treatment of 150,000 patients a year. The clinics of Washington University on Jefferson Avenue, O'Fallon Dispensary on Locust Street and St. Louis Children's Hospital, were closed December 12, and the patients formerly treated are now being sent to the new dispensary which occupies two floors of one of the new university buildings on Euclid Avenue. One of the special activities of the new dispensary will be the social service department which will have in its charge the investigation of the home conditions which produce disease, and devise plans for correcting them.

NEW YORK

Free Wassermann Test.—Dr. Frederick W. Sears, health officer of Syracuse, announced on December 9, that henceforth the Wassermann test will be given free of charge to any person in the city who desires it.

Sanatorium Proposition Defeated.—By a vote of sixteen to eleven, the Otsego County Board of Supervisors, on December 11, defeated the proposition to put the question of the erection of a county tuberculosis sanatorium to a vote at the general election next fall.

New Tuberculosis Hospital.—A special committee of the Board of Supervisors of Cattaraugus County, appointed to establish a county tuberculosis sanatorium, met in Olean December 10, and signed the final papers which gave the county title to land in Rock City as a site for the institution, the construction of which will begin in the early spring. The building will accommodate from 36 to 40 patients.

Message to Health Officers.—The current issue of *Monthly Bulletin of the New York State Department of Health* contains a message to the health officers of New York state from Dr. Montgomery E. Leary, Rochester, president-elect of the New York State Sanitary Officers Association, in which he outlines a plan for still further increasing the usefulness of the association in the promotion of public health. This plan includes the establishment of branches of the association in every county, and of auxiliary organizations among the laity.

New York City

Personal.—Dr. Alvah H. Doty has been appointed consulting expert on communicable diseases in the State Department of Health. Dr. Theobald Smith has been appointed consultant in animal pathology.

PENNSYLVANIA

Will Establish Private Hospital.—The Southern Schuylkill County Medical Society has decided to establish a large private hospital at Schuylkill Haven.

Personal.—Dr. B. F. Haagen, Altoona, was seriously injured in the spine and left arm by the overturning of his automobile in Collinsville, December 7.——Dr. J. Clyde Enos, Charleroi, sustained a fracture of the skull and injuries to the spine in a collision between his automobile and a street car.——Dr. Johnston McLanahan, Chambersburg, is reported to be seriously ill with heart disease.

Philadelphia

Personal.—Drs. Charles Snowden Pancoast and E. Kilbourn Tullidge, sailed December 8 for Genoa, Italy, on their way to Vienna where they will serve as volunteers in the military hospitals.

Fair for War Relief.—At the Made-in-America fete held in Horticultural Hall, December 14 to 16, the proceeds of the doctors' booth were devoted to the sending of surgeons and medical supplies for the relief of those in the war zone, and the proceeds of the American Ambulance Ball, December 15, were utilized for the establishment of beds in the newly planned Philadelphia ward of the American Ambulance, Paris.

TEXAS

Personal.—Dr. E. D. Fyke, Fort Worth, has been appointed state health officer.——Dr. Irvy L. McGlasson, for four years state quarantine officer at Galveston, will relinquish his office and return to Waco to practice February 1.——Dr. Morris H. Boerner, Austin, has resigned as assistant state health officer, to take effect January 15.

Free Diphtheria Antitoxin for the Poor.—Diphtheria is said to be prevalent throughout the state of Texas, though in a mild form. Arrangements have therefore been made through the State Board of Health with local health officers, whereby those unable to pay for it may obtain diphtheria antitoxin free in the larger cities of the state and at very low prices in other portions of the state.

State Board Appointments.—The governor has made the following appointments of the State Board of Health: Drs. Lawrence W. Hollis, Abilene; Carl W. Hoeflich, Houston; Louis M. Weinfield, San Antonio; Hugh L. McLaurin, Dallas; William D. Littler, Fort Worth; Harmon J. Childress, Gilmer, and E. M. Wood, Georgetown.——State Board of Medical Examiners: Drs. J. J. Williams, Groesbeck; John H. McLean, Fort Worth; Arthur M. McElhannon, Sherman; John S. McCelvey, Temple; William B. Collins, Lovelady; H. B. Mason, Temple; L. S. Scothorn, Dallas; Horace C. Morrow, Austin; Thomas J. Crowe, Dallas; Marion A. Cooper, Childress, and F. M. Butencourt, Falls County.——Quarantine Officers: Drs. Duke H. Huffaker, El Paso; S. E. McCain, Brownsville, Marquis D. L. Jordan, Velasco; Everette O. Arnold, Corpus Christi; Justus S. Davidson, San Felipe, and H. C. Hall, Laredo; and Registrar of Vital Statistics: Dr. William A. Davis, Jr., Jourdanton.

WISCONSIN

Personal.—Dr. Ray R. Harris, formerly in charge of the Old Sanatorium, Prairie du Chien, has moved to Dubuque.——Dr. George Clyde Stimpson, White Creek, has been appointed an intern in the Elgin State Hospital.——Dr. George Wallace Nott, Racine, fractured his right wrist while cranking his automobile, December 8.

CANADA

Faculty Offers Base Hospital Personnel.—The faculty of McGill University has offered the personnel for a mammoth base hospital for foreign service. The British war office has accepted this offer and the personnel and equipment will leave for England in March.

Personals.—The following medical men from Hamilton, Ont., will go with Canada's second war contingent: Drs. Geo. D. Farmer, Ancaster, Ont.; Daniel P. Kappele, William L. Silcox, William F. Nicholson.——Dr. John B. Leathes left Toronto December 13 for England, where he will take up his new duties in the University of Sheffield.——Dr. William E. Struthers, chief medical inspector of schools in Toronto, has resigned and has been appointed chief medical officer of the Workman's Compensation Board of Ontario.——Dr. Fernand L. de Verteuil, Vancouver, B. C., was the medical officer of the *Good Hope*, recently sunk off the Chilean coast.——Dr. Francis J. Folinsbee, Edmonton, Alberta, has been appointed resident house physician to the Great Ormond Street Hospital for Sick Children, London, England.——Dr. Robert Mayrand, Quebec, is on active service in the war zone as surgeon of Base Hospital No. 1.——Recently a bust of the late Dr. Emily Stowe was presented to the city of Toronto by a number of her friends. Dr. Stowe was the first woman physician to practice medicine in Ontario.

GENERAL

Church Medical Laboratory.—The medical laboratory authorized by the Missouri Conference of the Methodist Church, South, is to be named the Missouri Valley Foundation for the Conservation of Health. Dr. Daniel Morton, St. Joseph, is secretary of the board and Dr. William H. Minton, St. Joseph, a member of the foundation.

Bequests and Donations.—The following bequests and donations have recently been announced:

Boehme Tuberculosis Camp, Evansville, Ind., $1,000 by the will of Mrs. May Stockwell.

Jackson County, Mich., Antituberculosis Society, residence on West Washington Street, Jackson, to be held in trust after the death of his daughter, Mrs. Julia A. Mersereau, by the will of R. Bruce Coltrin.

Methodist Hospital, Philadelphia, $3,000 by the will of Elizabeth Brines.

A worthy Hospital in Philadelphia, $5,000 to endow a bed for persons suffering from cancer, by the will of Caroline J. Cammerer.

Meeting of Seaboard Physicians.—The Seaboard Medical Association of Virginia and North Carolina held its nineteenth annual session in Goldsboro, N. C., December 8, under the presidency of Dr. John Rainey Parker, Goldsboro. Dr. William L. Rodman, president-elect of the American Medical Association was the guest of honor at the meeting and delivered an address on "Cancer." Norfolk, Va., was selected as the 1915 place of meeting and the following officers were elected: president, Dr. Israel Brown, Norfolk, Va.; vice-presidents, Drs. Cicero F. Griffin, Winston, N. C.; Beverley R. Kennon, Norfolk, Va.; J. R. Parker, Gatesville, N. C., and John W. Winston, Norfolk, Va.; secretary, Dr. Clarence P. Jones, Newport News, Va. (reelected), and treasurer, Dr. George A. Caton, New Bern, N. C. (reelected).

FOREIGN

Revision of Italian Pharmacopeia.—In August the committee was appointed which is to have charge of the revision of the Italian pharmacopeia. It consists of Prof. E. Paterno, senator of the realm and incumbent of the chair of general and analytic chemistry at the University of Rome; Prof. V. Cervello, professor of materia medica and pharmacology at the University of Palermo; L. Pesci, director of the institute for chemopharmaceutics and toxicology at the University of Bologna; the pharmacist, A. Quercia of Bari, and T. Bosio of Turin.

WAR NOTES

Typhoid Epidemic Denied.—Gen. M. P. Melis, chief of the Belgian Medical Corps, in a London dispatch of December 9, denies the report that typhoid fever is epidemic in the Belgian army.

Red Cross Funds to Turkey.—The American Red Cross on December 16, cabled to the American ambassador in Constantinople, $10,000 to assist in the maintenance of numerous hospitals in Turkey.

The Budapest Red Cross Unit.—The Red Cross unit located at Budapest in charge of Dr. Charles McDonald of New York City, has established a hospital with accommodations for 200 wounded.

Red Cross Work in Servia.—The Servian Prime Minister and the Minister of Foreign Affairs have notified the American Minister at Bucharest, Romania, that the American Red Cross unit, under the direction of Dr. Ryan, has taken over the hospitals at Belgrade, Servia, including the medical personnel and pharmacists.

Artificial Pneumothorax on the Firing Line.—Rist relates that a rapidly progressing tuberculous process in the right upper lobe with stormy onset in September, 1913, was arrested by artificially induced pneumothorax, and the young Frenchman took his place last August on the firing line. For a month he was subject to the vicissitudes of the rapidly shifting front rank in the active campaign but came through it in good condition, free from fever or cough. Some effusion in the pleura had helped to maintain the compression of the lung. A little effusion had been noticed just before he left for the front.

Canada Aids Red Cross Work.—The Canadian Red Cross Society has been requested to equip five field hospitals and three field ambulances for the Canadian Contingent. They will aggregate 2,000 beds, a capacity about four times that of the Toronto General Hospital. They will consist of two general hospitals, of 520 beds each; one clearing hospital, 200 beds; two stationary hospitals, 200 beds each, and three field ambulances, 150 beds each. The Aesculapian Club, Toronto, has voted $200 to the Belgian fund; $100 to the Canadian Patriotic Fund and $50 to the fund for comforts for Canadian soldiers.

LONDON LETTER

London, Dec. 4, 1914.

The War

Among the wounded the almost complete absence of rifle bullet wounds is striking; they constitute only about 1 or 2 per cent. The rest are due to shrapnel and to "high velocity" percussion shells. The shrapnel bullet does not make a very bad wound, though it often drives clothing in, but the wounds made by large pieces of common shell are horrible. Heads, arms, feet, etc., are blown off, and in other cases most dreadful flesh wounds and fractures result. The shell fragments drive clothing and mud deep into the tissues and cause both tetanus and spreading gangrene in many cases. The latter are treated by free incisions and injections of hydrogen peroxid subcutaneously, and if the treatment is begun soon enough, life and sometimes limbs are saved. Most of the tetanus cases are fatal, in spite of prophylactic serum.

GALLANTRY OF ARMY SURGEONS

As stated in previous letters, death has taken a heavy toll from the army surgeons, who have shown great bravery in the discharge of their duties. Only about a dozen Victoria crosses, granted only for extraordinary bravery in the field, have been awarded so far in this war, although our troops have fought with all their traditional valor. Another high distinction is the "Distinguished Service Order" (colloquially called the "D. S. O."), which has been awarded to fifty-eight officers in recognition of their services. The list includes three army surgeons who showed great bravery in attending to the wounded under fire. Since my last list another army surgeon has died of wounds, and another is "missing." In the battleship which was blown up, apparently as the result of an accident, three naval surgeons perished.

THE BELGIAN WOUNDED

Some further particulars with regard to the part played by this country in succoring the Belgian wounded may be of interest. When the Germans occupied all the important towns, the Belgian hospitals fell into their hands. The wholesale exodus of the population included all the wounded who could be moved, and furnished a gigantic problem. The British Red Cross was first approached, but as its duty was to attend to the British wounded, it was unable to use its organization. However, they gladly subscribed $5,000, and a "Wounded Allies Relief Committee" was formed. Subscriptions were raised and a small number of convalescent were brought from Antwerp to England. Premises for a hospital were secured at a seaport, Ramsgate. Two English physicians were sent over to Ostend just before its evacuation, and found the appalling condition of 10,000 wounded and 3,000 more to arrive on the morrow. Every available space and even railway sidings were crowded by the wounded. There were few surgeons or trained nurses and hardly any medical stores. The British government then came to the rescue and sent transports which brought away the wounded to England, where the naval and military authorities helped to disembark them. In the meantime telegrams were sent to the mayors of a number of large towns asking if they would receive batches of fifty wounded Belgian soldiers and see that they were properly treated at the local hospitals, to which they readily assented. The Admiralty sent to Ostend as many as five transport ships in thirty-six hours, and from October 12 to 15, 12,000 wounded were brought away. At the present time 18,000 wounded Belgians are under treatment in England. When they become convalescent they are sent to private houses whose owners have offered their hospitality. Thus by the cordial cooperation of the government and private citizens this gigantic problem has been efficiently solved.

OUTBREAK OF TYPHOID FEVER IN THE BELGIAN ARMY

An epidemic of typhoid fever is threatening in West Flanders and Northeastern France. Many of the Belgian soldiers have been attacked, which is causing some concern to the British Army Medical Service, lest the disease should spread to our troops who are fighting in close cooperation with the Belgians. Cases are coming into Calais at the rate of about ten a day. The British Red Cross has acted with great promptitude and made an immediate grant of $50,000 for the Belgian soldiers at Calais suffering from typhoid fever. The French authorities have given orders for a ship to lie in the dock basin to which the fever patients will be conveyed as soon as the diagnoses are made, and arrangements for the erection of an isolation hospital are under way. Thanks to the extensive inoculation of the British troops, very few cases have occurred among them.

THE MANUFACTURE OF ANILIN DYES

As most of the anilin dyes are manufactured in Germany and their import has been prohibited since the war, a difficulty has been created in the textile industries. To meet this emergency the government has endeavored to induce British manufacturers of dyes to turn their attention from the making of dyes for export to the making of dyes necessary for our own industries. To aid those manufacturers the government has taken steps to persuade works used for the distillation of coal-tar to produce the intermediate bases of the dyes which hitherto have been mainly obtained in Germany. But these emergency arrangements will supply no more than one-third of the consumption of dyes in this country. It has been proposed to form a national organization for the production of dyes, and the government has offered to support it on the conditions that those engaged in it subscribe the whole of the ordinary capital and that they also undertake to continue to buy their dye-stuffs from this cooperative concern. If the consumers will subscribe $12,000,000, the government is prepared, subject to a certain control, to guarantee debenture interest on another $7,500,000. The government will require that it have two nominees on the board, that it have the right of veto to secure that the concern shall remain permanently under British control, and that the large consumer shall have no advantage in price over the small consumer.

ESTABLISHMENT OF A LARGE HOSPITAL FOR THE WOUNDED

The government has placed at the disposal of the War Joint Committee of the British Red Cross and the St. John Ambulance Association the new Stationery Office in London which will be adapted to the needs of a hospital for the wounded. It is estimated that the hospital will contain 1,650 beds. An appeal is being made to the public for their equipment and money is being subscribed at the rate of about $50,000 a day; $125 provides a bed and its necessary equipment. To each bed so provided will be affixed a tablet with the donor's name.

THE PREVENTION OF VENEREAL DISEASE

A national council for combating venereal disease has been formed with the support of the leaders of the medical profession, the churches and others. It marks an important advance in the campaign initiated by Major Leonard Darwin, president of the Eugenics Education Society. Sir Thomas Barlow, who presided at the inaugural meeting, pointed out that, while war conditions limited the possibilities of the movement in some respects, they also opened up opportunities which must not be missed. The aggregation of large bodies of young men in camps offered them a special field. The military authorities were fully alive to their own duties in this regard, and were even now devising an educational scheme for meeting the need in this great national emergency. If they should require aid from the outside, the medical profession would not be slow to put their shoulders to the wheel. The work was heartily welcomed by Lord Kitchener. But the subject had its civil as well as its military aspect, and there was ample room for cooperation by civil authorities and by organizations for social welfare, and not least by women, both medical and lay, and by those excellent agencies which were providing tents and means of sane recreation for the soldiers. While the problem was primarily medical, its solution could not be attained without the hearty cooperation of every kind of agency for social betterment. He moved that the following aims be the objects: 1. To provide accurate and enlightened information as to the prevalence of these diseases, and as to the necessity of early treatment. 2. To promote the provision of greater facilities for their treatment. 3. To increase the opportunities of medical students and practitioners for the study of these diseases. 4. To encourage and assist the dissemination of a sound knowledge of the physiologic law of life in order to raise the standard both of health and of conduct. 5. To cooperate with the existing associations, to seek their approval and support, and to give advice when desired. 6. To arrange, in connection with such organizations, for courses of lectures, and to supervise the preparation of suitable literature. 7. To promote such legislative, social and administrative reforms as are relevant to the foregoing aims and objects.

THE SALE OF DRINK TO SOLDIERS

Another danger to soldiers is being guarded against. The government has issued an order giving the naval and military authorities power to close all saloons within any area for certain hours, either generally or as respects the members of the army and navy. Attempts to elicit information for the enemy by giving or selling intoxicants to seamen or soldiers is made an offense.

BERLIN LETTER

BERLIN, Nov. 24, 1914.

The War

According to the latest reports from the seat of war, the number of cases of typhoid and dysentery observed is still small. Whether the opportunity for infection is lacking or the extensive protective inoculations to which our troops have been subjected against typhoid explain this fact cannot be decided at present. The injection material is prepared for the most part according to the improved process of Fornet, at least in Berlin and in the army laboratories, especially in the Kaiser Wilhelm Academy for the instruction of army surgeons. Also the hygienic institutes of the other federal states prepare typhoid and cholera vaccines. With the exception of two persons who wandered over the border, cholera has not been observed in Germany, which is all the more remarkable since it is constantly prevalent in Austria, particularly in the neighboring province of Galicia, and the communication of the disease is facilitated by the combination of the armies. The troops have also been inoculated against cholera but not to so great an extent as against typhoid. In the proceedings of the individual medical societies, which have almost wholly been converted into unions of military surgeons, tetanus occupies a prominent place as formerly. There is still no agreement as to the success of tetanus antitoxin, but the reports of favorable results seem to be increasing. The injection of magnesium sulphate secured at least a symptomatic success, and many an author believes that he has observed a curative effect. It is quite remarkable to what an extent the scientific enthusiasm of our physicians comes into expression under the difficult conditions in the field. In many places scientific societies have been formed in the hostile countries, where from time to time discussions occur. In Lille, a German clinic has been organized out of the university clinic of the Hospital St. Sauveur, which has been transformed by its conductor, Professor Krönig of Freiburg, into a center of scientific activity for physicians in Lille and its neighborhood. In Namur, a German-Belgian physicians' association has been founded which has already held four meetings with thirty to forty participants under the presidency of the garrison surgeon of that place, Professor Schilling, an investigator of tropical diseases from the Berlin Institute for Infectious Diseases. The interpreter is a Belgian army surgeon who studied in Germany for a number of years. This recalls the fact that also in the Franco-Prussian War Professor Langenbeck founded a scientific association in Orleans. In Berlin almost all of the medical societies have united with the greatest medical association of Berlin and also of Germany, the Berlin Medical Society, so as to scatter the material as well as the audience as little as possible. The society meets once in two weeks instead of every week as formerly, alternating with the army medical society which holds its meetings under the presidency of the former Leipsic surgeon, Professor Trendelenburg, who, since resigning his position, is living in Berlin.

PHYSICIANS IN CIVIL PRACTICE

As may be seen from the meetings of the Berlin Medical Society, the number of physicians still carrying on a civil practice is diminishing, although somewhat gradually. The continual increase of the armies by the addition of the reserves demands, on the one hand, a greater number of field surgeons to accompany them. On the other hand, the number of wounded accumulating in the hospitals demands a greater amount of surgical treatment. Naturally, the demands for this work cannot be limited to those physicians who have served as army surgeons, but now those are employed in their home hospitals who, for any physical causes, have not been found fit for military service. All these physicians are paid a sum of twenty marks ($5) a day in addition to their expenses. Germany does not lack money and food for these purposes. Not only in Berlin but also in practically all other parts of the country, so far as it has not been laid waste on the eastern and western boundaries, there is no scarcity of food to be noted on account of the war. According to the statement made by Professor Rubner, the physiologist, a few weeks ago in an article in the *Deutsche medizinische Wochenschrift*, there is no need to fear the subjugation of Germany by hunger.

Marriages

OSSIAN H. KING, M.D., Vincennes, Ind., to Miss Margaret McDonald of Nashville, Tenn., at Vincennes, December 2.

JAMES L. STEWART, M.D., Boise, Idaho, to Mrs. Modjeska Fleharty of California, at Salt Lake City, November 25.

ROBERT MAFFETT PALMER, M.D., Pottsville, Pa., to Miss Olive Frances Mayer of Johnstown, Pa., October 22.

JOHN PERCIVAL HEWSON, M.D., Orange, Texas., to Miss Anna E. Salmon of Wilkes-Barre, Pa., December 3.

CECIL HARROD DICKERSON, M.D., Conway, Ark., to Miss Nine Martin of Indianola, Miss., November 25.

WALTER M. L. ZIEGLER, M.D., Philadelphia, to Mrs. Mary Alice Dolson of New York City, November 28.

HENRY JOSEPH EUGENE NEWNAM, M.D., to Miss Lillian F. Hopkins, both of Philadelphia, November 26.

CLARENCE HERBERT MORIAN, M.D., Arvada, Colo., to Miss Lelah M. Hart of Denver, December 2.

GARRETT LEE HYNSON, M.D., to Miss Helen Rebecca Sibel, both of Portland, Ore., November 25.

HENRY H. FLOOD, M.D., Baltimore, Md., to Miss Adelaide Selby of Ivory, Md., November 26.

JAMES BERRY GILBERT, M.D., to Miss Edna Ruth Wilson, both of Tulsa, Okla., November 29.

ROBERT L. SCHAFFER, M.D., to Miss Millie L. Ochs, both of Allentown, Pa., November 30.

BEVERLY W. HALL, M.D., Bowman, Ga., to Miss Alva Harris at Rome, Ga., November 12.

Deaths

George W. Lasher, M.D. Rush Medical College, 1872; a Fellow of the American Medical Association and formerly president of the Los Angeles County Medical Association and Southern California Medical Society; for twenty-five years professor of surgery in the University of Southern California, Los Angeles, and since 1910 emeritus professor; for eighteen years house physician of the Hollenbeck Hotel, Los Angeles; died at the home of his office associate, Dr. W. F. Perry, in that city, December 4, from cerebral hemorrhage, aged 69.

Johnston McLanahan, M.D. Jefferson Medical College, 1865; a member of the Medical Society of the State of Pennsylvania; formerly president of the Medical Society of Franklin County and treasurer of the organization for many years; surgeon of United States Volunteers from 1863 to 1866; president of the Board of Health of Chambersburg for several years and a director of the Chambersburg National Bank; died at his home in that city, December 13, from valvular heart disease, aged 70.

Jephtha Vining Harris, M.D. Tulane University, New Orleans, 1861; assistant surgeon and chief surgeon, C. S. A., and assistant surgeon, C. S. N., during the Civil War; a member of the Florida legislature, 1877; superintendent of public instruction of Monroe County, Fla., for ten years, and collector of customs at Key West, from 1885 to 1889; died at the home of his son in Key West, Fla., November 21, aged 75.

William H. Capener, M.D. Western Reserve University, Cleveland, Ohio, 1856; examining surgeon for the Army during the Civil War; surgeon of the U. S. Marine Hospital, Cleveland, in 1860 and 1861; health officer of the city, from 1871 to 1873, and surgeon to the City Infirmary for four years; died at his home in Cleveland, December 2, aged 82.

Gard Wilmarth Foster, M.D. Detroit Medical College, 1873; a member of the Medical Society of the State of New York and a specialist in diseases of the eye, ear, nose and throat of Auburn, N. Y.; while en route to Bermuda in search of health, died December 2, in Schenectady, N. Y., from pneumonia, after a surgical operation.

William Taylor Johns, M.D. St. Louis College of Physicians and Surgeons, 1912; professor of physiology and serology in his Alma Mater in 1911-12; director of the Western Wassermann Laboratories, Muskogee, Okla.; was found dead in his office in Muskogee, December 7, from tuberculosis, aged 39.

Moris Drake, M.D. Medical College of Ohio, Cincinnati, 1881; a Fellow of the American Medical Association and a well-known practitioner of Indiana; died at his home in Shelbyville, December 12, from gastric ulcer associated with and dependent on carcinoma of the stomach, aged 58.

James Harper Ramsey, M.D. Western Reserve University, Cleveland, 1871; a veteran of the Civil War; for several years a member of the school board of Bridgewater, Pa.; and once president of the board of health; died at his home in West Bridgewater, Pa., November 25, aged 79.

Robert Harris Bradford, M.D. North Carolina Medical College, Charlotte, 1904; surgeon for the Inter-State Lumber Company, at Burgaw, N. C.; died in the James Walker Memorial Hospital, Wilmington, N. C., November 25, three weeks after an operation for appendicitis, aged 36.

George Edward Maloy, M.D. University of Vermont, Burlington, 1877; for many years a practitioner of Glencoe and St. Cloud, Minn.; but for the last three years a resident of the Pacific Coast; died at the home of his son in Spokane, Wash., November 25, from carcinoma, aged 59.

James Ball, M.D. Kansas City Homeopathic Medical College, 1893; a Fellow of the American Medical Association; for twenty years a practitioner of Ottawa, Kan.; died in Bethany Hospital, Kansas City, Mo., November 26, after an operation for intestinal obstruction, aged 48.

John M. Fraser, M.D. Western Reserve University, Cleveland, 1881; a Fellow of the American Medical Association; formerly a member of the faculty of the Wooster University Medical College; died at his home in Cleveland, November 30, from cerebral hemorrhage, aged 62.

Baldwin Gardiner Cooke, M.D. College of Physicians and Surgeons in the City of New York, 1879; for more than eighteen years medical and sanitary inspector for the Department of Health of New York City; died at his home in New York City, December 8, aged 59.

William T. Heidt, M.D. Savannah (Ga.) Medical College, 1857; one of the oldest members of the Chatham Field Artillery, Savannah, and surgeon of that organization during the Civil War; died at his home in Bloomingdale, Ga., December 7, aged 77.

Albert Brinkman, M.D. New York University, New York City 1883; for many years visiting surgeon to the Brooklyn Eye and Ear Hospital; died at the home of his brother in Brooklyn, December 7, from the effects of an overdose of morphine, aged 52.

Josiah Claire Violet, M.D. Northwestern University Medical School, Chicago, 1910; a Fellow of the American Medical Association and formerly a resident of Chicago; died in Pomona, Cal., where he had gone in search of health, November 22, aged 32.

Jacob F. Trump, M.D. University of Vermont, Burlington, 1881; a specialist of diseases of the eye, ear, nose and throat of Hamilton, Ohio; died in Mercy Hospital in that city, December 8, after the amputation of his right leg for gangrene, aged 63.

William Robert Moore, M.D. Starling Medical College, Columbus, Ohio, 1889; a member of the Ohio State Medical Association and a member of the staff of the Deaconess Hospital, Ironton, Ohio.; died at his home in that city, December 4, aged 41.

George Dexter Bullock, M.D. Jefferson Medical College, 1886; formerly a Fellow of the American Medical Association; a member of the Massachusetts Medical Society; died at his home in Weymouth Landing, Mass., December 6, aged 55.

George Herbert Burke, M.D. Chicago Homeopathic Medical College, 1898; a member of the Hospital Corps during the Spanish-American War, with tropical service; died at his home in Wabash, Ind., December 4, from heart disease, aged 51.

Thomas Osborne Hunter, M.D. Memphis Hospital Medical College, Memphis, Tenn., 1889; a pathologist and health officer of Biloxi, Miss., and at one time state registrar; died suddenly in Biloxi, December 3, from heart disease, aged 46.

Wesley J. Green, M.D. Atlanta (Ga.) Medical College, 1888; a member of the Medical Association of Georgia; for many years a practitioner of Clayton, Ga.; state senator from 1898 to 1900; died in Clayton, Ga., November 28, aged 51.

Sumner A. Stacy, M.D. New York Homeopathic Medical College, New York City, 1886; died at his home in Adamsville, Ohio, December 4, from valvular heart disease, aged 57.

John Harrod, M.D. Eclectic Medical Institute, Cincinnati, 1887; died at his home in Fort Wayne, Ind., December 8, from heart disease, aged 53.

William Grange Dolan, M.D. Rush Medical College, 1902; a member of the Minnesota State Medical Association and for twelve years a practitioner of Cloquet, Minn.; died in Jacksonville, Fla., December 5, from diabetes, aged 37.

Charles S. Albertson, M.D. Homeopathic Hospital College, Cleveland, 1882; a member of the staff of the Oswego(N. Y.) Hospital and of the Medical Society of the State of New York; died at his home, December 7, aged 62.

Elias Lawrence Brownell, M.D. University of Vermont, Burlington, 1868; a pioneer practitioner of Dickinson County, Iowa; died at his home in Spirit Lake, Ia., about December 2, from sciatic rheumatism, aged 71.

Elden Cromwell Sturman, M.D. College of Physicians and Surgeons, Keokuk, Ia., 1897; a member of the Iowa State Medical Society; died at his home in Hartford, Ia., November 29, aged 45.

Robert W. Sharp, M.D. Eclectic Medical Institute, Cincinnati, 1873; a member of the Ohio State Medical Association; died at his home in Buckland, Ohio, about November 22, aged 64.

Milton I. Hatfield, M.D. Eclectic Medical College of Pennsylvania, Philadelphia, 1870; died at his home in Warren, Ohio, November 30, five weeks after a surgical operation, aged 69.

John W. Morgan, M.D. Medical College of the State of South Carolina, Charleston, 1857; formerly of Minden, La.; died at his home in Coushatta, La., November 29, aged 84.

James A. Wamsley, M.D. Jefferson Medical College, 1878; of Philadelphia; died at the German Hospital in that city, December 4, after an operation for appendicitis, aged 63.

Harvey M. Dally, M.D. Medical College of Indiana, Indianapolis, 1881; a physician and druggist of Pontiac, Ill.; died at his home in that place, November 29, aged 59.

Louis Seraphin Poulin, M.D. University of the Victoria College, Coburg, Ont., 1867; died at his home in St. Alexandre d'Iberville, Que., September 26, aged 70.

Isaac R. Hogue, M.D. Hahnemann Medical College, Chicago, 1892; for many years a school teacher; died at his home in Elkhart, Ind., December 2, aged 82.

Ira John Schott, M.D. Hahnemann Medical College, Chicago, 1887; of Naperville, Ill.; died suddenly from heart disease in that place, November 21, aged 54.

James R. Seymour, M.D. Eclectic Medical Institute, Cincinnati, 1883; died at his home in Raymond, Ill., November 28, from cerebral hemorrhage, aged 65.

Solomon Singer, M.D. University of Toronto, Ont., 1903; a coroner of Toronto; died at his home in that city in October, from typhoid fever, aged 37.

John Edward Waterhouse, M.D. University of Colorado, Boulder, 1912; died at the home of his mother in New Orleans, November 27, aged 26.

Shelvey Maddox, M.D. Eclectic Medical Institute, Cincinnati, 1881; died at his home in Monroe City, Mo., November 28, from diabetes, aged 61.

Alexander Peter O'Malley, M.D. New York University, New York City, 1876; died at his home in Wilkes-Barre, Pa., December 12, aged 61.

John T. Anderson (license, Indiana, 1897) a practitioner since 1893; died at his home in Swayzee, Ind., about December 1, from pneumonia.

John Winfield Reith, M.D. Hahnemann Medical College, Philadelphia, 1905; died at his home in Lancaster, Pa., December 9, aged 32.

Adeline Wilkins Wildes, M.D. Boston University School of Medicine, 1881; died at her home in Roxbury, Boston, December 6, aged 74.

John August Lock, M.D. Eclectic Medical College of the City of New York, 1910; died at his home in Brooklyn, December 4, aged 31.

Thomas Henry Moore, M.D. Maryland Medical College, Baltimore, 1912; died at his home in Willimansett, Mass., October 21, aged 26.

Henry Reid McCullough, M.D. Trinity Medical College, Toronto, Ont., 1887; died at his home in Harriston, Ont., October 21, aged 49.

James Frederick Shurtleff, M.D. Albany (N. Y.) Medical College, 1867; of Rock, Mass.; died in Middleboro, Mass., October 22, aged 72.

Charles Henry Reed, M.D. University of Pennsylvania, Philadelphia, 1878; died at his home in Philadelphia, November 24, aged 62.

Harold Middleton Shephard, M.D. McGill University, Montreal, 1910; died at his home in Ingersoll, Ont., October 20, aged 27.

John Clossom Ray, M.D. University of the Victoria College, Coburg, Ont., 1862; died at his home in Toronto, Ont., October 17.

William S. Turner, M.D. Vanderbilt University, Nashville, Tenn., 1882; died at his home in Blakemore, Ark., December 1, aged 60.

Siddar Morgan (license, Colorado, ten years of practice, 1900) died at his home in Denver, Colo., November 23, aged 60.

C. H. Bates, M.D. Kentucky School of Medicine, Louisville, 1871; died at his home in Osyka, Miss., September 23, aged 67.

George Mitchell, M.D. Bellevue Hospital Medical College, 1866; died at his home in Wallaceburg, Ont., October 2, aged 78.

Willard A. Hall, M.D. Miami Medical College, Cincinnati, 1876; died at his home in Yoakum, Texas, December 2, aged 63.

Robert Lee Rye, M.D. University of Louisville, Ky., 1897; died suddenly at his home in Porter, Okla., December 4, aged 43.

Allan Aleyne Mathews, M.D. Rush Medical College, 1879; of Oak Park, Ill.; died November 19, aged 61.

Correspondence

Medical Notes on England at War

To the Editor:—I dare say my many friends in the United States and Canada would like to have a few notes of my recent experience during these busy months.

It has been an extraordinarily interesting sight to watch the transformation of a peaceful commercial country into an armed camp. As regards soldiers, four months ago England was in the same blissful condition as the United States. One knew there was an army, but a soldier was never seen. To-day khaki is the "only wear," and there are more than 1,000,000 in training, and some 300,000 at the front, a larger expeditionary force than England has ever had on the Continent. And there is a fine spirit abroad. Every one is working, the Irish question is dead, an intense pride has been raised in the army, there is every confidence in the navy. At the first blush it really looks as if war were a good thing, a fine tonic to the country at large; but behind all this is the tragedy of the shambles at the front, and the hospitals are full of poor fellows battered and shattered, so that one has not to go far to realize the truth of Sherman's famous words that "War is Hell."

For the medical work England was not wholly unprepared. The lessons of the South African War sank deeply and gave a good many men now in the prime of life a most helpful experience. Then in the reorganization of the territorial army five or six years ago the country was divided into military districts, in each one of which a base hospital was organized. Thus Sir Alfred Keogh, the Director-General, and Colonel James came here, met the profession, explained the details of the reorganization, and left the matter in the hands of a committee who nominated the staff, selected the buildings, and arranged for nurses. This was all on paper, but the skeleton was laid down, and the large examination schools selected as the hospital. The plans for the alterations had been prepared, and life had been kept in the organization by an annual meeting. And so it turned out that within two weeks after the order for mobilization, Colonel Ranking, the administrator, had the schools ready for a hospital of nearly 500 beds, and a staff organized. The same has taken place in the other centers throughout the country, so that ample accommodation was provided, both for the sick among the territorials and Kitchener's new army, and for the wounded who soon began gradually to be sent back from the front. At present in Oxford there are nearly 1,000 beds available, as the town hall and the workhouse

have been added and about eighty beds provided at the Radcliffe Infirmary. Up to date, between 2,000 and 3,000 wounded have been treated.

Private enterprise has also furnished excellent hospitals. The Committee of American Ladies in London has opened the American Hospital at Paignton, near Torquay in Devonshire, in the splendid house handed over to it by Mr. Paris Singer. There are 200 beds, and an additional sixty beds will be provided. The work is in charge of Dr. Beal of the American Red Cross.

The Canadians resident in London have opened a hospital near Shorncliffe, which is in charge of Dr. Armour and myself, in a house provided by Sir Arthur and Lady Markham. The resident surgeons are Dr. Wallis of Guelph and Dr. Stewart of Calgary. Miss Macmahon of Toronto, formerly one of the assistant superintendents at the Johns Hopkins Hospital, is in charge with a group of Canadian nurses.

From the base hospital in Oxford the convalescents flow over to Blenheim Palace, the library of which has been converted into a ward for sixty patients, and to Lady Wantage's at Lochinge, and to Mr. Mortimer Singer's at Milton Hill. The latter is one of the most ideal hospitals I have ever seen. Mr. and Mrs. Singer were about to move into their newly arranged house, but have converted it into a hospital for 150 beds, and are providing everything for the comfort of the soldiers.

In Cambridge, Birmingham, Bristol and London large hospitals have been opened, and many of the Metropolitan hospitals have set aside a certain number of beds, so that one may say that the accommodation throughout the country both as regards hospitals and convalescent homes is ample.

Altogether, the health of the troops in the training camps has been excellent, and, fortunately, until recently the weather has been good. Up to date there has been no typhoid to speak of. Inoculation is not compulsory, so that a number of us have been going about the camps lecturing to the men, the large majority of whom have readily submitted to inoculation. The country districts in England are singularly free from typhoid, so that there is not much risk of wide-spread epidemics in the camps, and in the British expeditionary forces there have been very few cases. There has only been one case at Paignton, and only four or five here. I saw a couple in the hospitals at Brighton. In these first four months of the war we may say that typhoid has played no part. Major Russell's recent figures of the results of inoculation in the American army have been of great value in convincing officers of the value of the procedure.

The outstanding medical feature of the campaign in France and Belgium is that wounded, not sick, are sent from the front. So far, disease has played a very small part and the troops have had wonderful health, in spite of the exposure in the trenches. The damage has been from the pointed bullet, the round shrapnel bullet, and from fragments of the shrapnel case, and the severity of the wounds caused are in this order. From the military point of view, the modern bullet is not a very effective agent. At the right spot it kills; but it may pass harmlessly through head, chest or abdomen, and may splinter a bone without causing sepsis. The orifices of entrance and exit are small, heal rapidly, and the high velocity appears to sterilize the tract. I have seen one case of bullet through the frontal lobes, four through the chest, and two through the abdomen without serious symptoms. The chest cases are of special interest, as one would not think it possible for a bullet to pass through pleura and lung without damage. At Paignton there have been three cases without pleurisy or hemothorax. In one the bullet entered the second right interspace, passed through the anterior mediastinum and the margin of the left lung and came out in the second interspace, about four inches from the left sternal border. Cough and hemoptysis followed, but the patient rapidly recovered. In another man the point of entrance was to the left of the nipple and the exit below the angle of the right scapula. He spat blood at first, but when I examined him about two weeks later there was no friction, flatness or effusion. A Belgian at Shorncliffe, wounded a week previously by a bullet through the right lung, had the same negative features. The patient in the next bed had hemothorax, with moderate fever, from a bullet which had passed through the right lung at the level of the fourth rib. When hemorrhage follows, there may be fever at first, though not necessarily, and if left alone, the symptoms subside, the clot organizes, the plasma is absorbed, and the affected side becomes immobile, with narrowed interspaces and even rapid contraction.

It would not seem possible that a bullet could go through the abdomen without doing any harm, but a Highlander at the base hospital, Oxford, had the wound of entrance about two inches to the left of the navel and the exit about three inches from the spine. He had had no abdominal symptoms, but had a bad shrapnel wound of the leg. In another man at Paignton the bullet entered from behind, and the roentgenogram showed it not far from the navel. No symptoms followed. The modern rifle bullet may leave a clear wound which quickly scabs over and heals rapidly. A Belgian student at Shorncliffe had a bullet through the bridge of the nose — fortunately a good-sized one — with little or no damage except a frontal sinusitis. The round shrapnel bullet does more harm, with a bigger orifice and a larger, and sometimes rugged, exit. This is an artillery war in which shrapnel does the damage, tearing flesh, breaking bones, and always causing jagged, irregular wounds. And here comes in the great tragedy — sepsis everywhere, unavoidable sepsis! The conditions on the battlefield have made it impossible always to give first aid, and within twelve and twenty-four hours the ragged open wounds have become infected from the clothing or the soil. The surgeons are back in the pre-Listerian days and have wards filled with septic wounds. I have seen sights that remind me of student days at the Montreal General Hospital when all the compound fractures suppurated, and we dressers really had to dress wounds. It may be possible to improve conditions, and already the transport of the wounded from the front has been hastened, and measures are being taken to provide simple antiseptics; but the wound of shell and shrapnel is a terrible affair, and infection is well-nigh inevitable. It is surprising what may be done in some of the worst cases. Among the first batch of German wounded admitted to the Oxford base hospital was a man with high fever, right hemiplegia and aphasia. He had a large wound of the skull on the left side. I saw him with Mr. Whitelocke, as meningitis was feared, but after the wound was freely opened and a part of a bullet and a bit of his cap were removed, the temperature fell, the paralysis cleared, and he has made a complete recovery. An interesting point is the extent of suppurating surface that may exist without fever so long as free drainage exists. It is, however, a slow tedious business, with a type of wound demanding much nursing and dressing. Two points then stand out prominently — the comparative mildness of the wounds of the high-velocity bullet, and the wide-spread prevalence of sepsis in the crusted and lacerated shrapnel wounds.

Two other infections have caused trouble. The fighting has been in highly cultivated districts where the tetanus bacillus thrives, so that many cases have developed. At first there was not sufficient antitoxin, but now it is given at the front as early as possible. There have been only two deaths here among seven cases. At Paignton two very severe cases recovered. The intrathecal method as warmly recommended by Park has been used. The other infection is more serious, an emphysematous wound gangrene, due to an anaerobic gas bacillus. It appears within the first four days of the injury and may prove rapidly fatal by sepsis. The emphysematous swelling, the spreading discoloration, gaseous discharge and terrible odor make the diagnosis easy. The phlegmon bacillus of Fränkel is a widely distributed organism, and infection probably comes from the soil.

There will be countless opportunities of studying lesions of the nervous system, particularly of the peripheral nerves. I have already seen several cases of severe neuritis of the type described in the monograph of Moorehouse, Mitchell and Keen, with great swelling. One patient at the American Hospital with a clean bullet wound high up on the inside of

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the arm has complete loss of power of the arm, with agonizing pain and great swelling. Later, it would be worth while for the government to concentrate these cases in one large hospital, as was done during the Civil War, and gave the authors just named their great opportunity. Perhaps the case that has interested me most was a paraplegia spastica cerebralis. The man, a private in the Lancashire Fusiliers, had a bullet wound at short range, which ploughed along the parting of his hair for about 3 inches, grooving the bone. It happened on September 13, and he was unconscious for a time, had loss of power in the legs and was carried into the cart. He gradually recovered the use of his legs, but has developed a spastic gait, with great increase in the reflexes. Another point of interest is the paralysis of the flexors of the feet, with some wasting. This makes the gait very remarkable, a combination of the spastic and steppage. No doubt here there was a bilateral hemorrhage, and an anatomic condition similar to that which occurs in Little's disease.

At the Beechborough Hospital there was a remarkable spurious aneurysm, in a Belgian shot through the right cheek; the bullet passed through the mouth, under the jaw beneath the skin of the neck, and was just below the left clavicle. The cervical triangle was filled with a pulsating mass, without thrill or bruit. It appeared to be a traumatic aneurysm, but Dr. Armour removed the bullet, relieving the tension, and the pulsation has gradually disappeared. It was probably hematoma with communicated pulsation. At Paignton there was an arteriovenous aneurysm of the left brachial which seemed doing very well at first, but then began to increase rapidly, so that Dr. Beal did an Antyllus operation.

Considering the distance that the wounded men have had to travel; from the front to the clearing hospital, then by ambulance train to the base hospitals, by ship to one of the ports, then by train or motor ambulance to the general hospitals—well termed a *via dolorosa*—their condition has been remarkable. The mortality has been everywhere very low.

I am sure your readers would like also to hear of the work which is being done to help our Belgian colleagues who have suffered so terribly. Within a week after the fall of Louvain one of the professors called and told such a sad story of their plight that we organized a university committee to offer hospitality to any who cared to accept, and my wife wrote at once to her friends in the United States asking for help. There are now sixteen Belgian professors here, with their families numbering nearly 100, for whom have been provided houses or lodgings, and who are given monthly grants for their support. The money for this has very largely come from our friends in the United States; and I would like here to express the indebtedness of the committee to Dr. J. William White of Philadelphia, and to Mrs. Futcher of Baltimore. The financial position has been greatly relieved by the kind offer of the Rockefeller Foundation to subsidize any science professors who wish to continue their work at English universities. The two most distinguished medical professors are Professor Denys, who is working in the laboratory here, and Professor Van Gehuchten in the Research Hospital at Cambridge, both from Louvain.

WILLIAM OSLER, Oxford, Dec. 4, 1914.

Sodium Chlorid in Bright's Disease

To the Editor:—Dr. Lowenburg's article in THE JOURNAL, Nov. 28, 1914, p. 1906, is of immense interest from the point of view of the effects of various mineral salts on metabolism, as well as of sodium chlorid in dropsy.

That sodium chlorid, taken into the circulation, will, under certain circumstances, cause water retention in the tissues (edema), I am fully convinced, but there may be, and there probably is, some other factor necessary for the production of that result. My opinion is that some etiologic factor is to be found in a peculiar condition of the tissues (such condition, in some degree, not unlike what we meet in chilblain cases), as well as in the pathologic condition of the kidneys. It is not generally known, perhaps, that potassium salts will counteract this water retention in the tissues by causing the sodium salts to be eliminated, and some articles of diet, such as potatoes, cereals, etc., which contain potassium in considerable quantities, will often prevent sodium chlorid from producing its characteristic effects on the tissues. Hence, probably one of the reasons for some contradictory results obtained by different clinicians owing to inattention to these details.

I have now in mind one particular case in point, which came under my observation in London, J. G., a man about 50, a plumber by trade, who had an attack of acute nephritis with albuminuria, general anasarca and other characteristic symptoms. The patient improved under treatment and resumed work in the spring of 1907. He felt tolerably well during the summer, but the case eventually ran into the chronic form, the condition of the patient becoming worse every winter through renewed attacks. He was admitted into the Middlesex Hospital during the winter of 1909-1910 and left little improved, to be sent shortly after to the Marylebone Infirmary. At that time he could walk fairly well, but had general edema and ascites. His condition, however, became gradually worse, notwithstanding the treatment he received and the continual use of Southey's tubes to reduce the dropsy, until during the last two months of the six which he remained in that institution, he was quite unable to walk owing to his size and weight from the dropsy. He could only move about in the corridors and in the yard with the use of a bath-chair which he wheeled with his hands. He thought that he would die if he remained there any longer, and he prevailed on his wife to take him out, although she had no other means to support him and herself than her daily labor at scrubbing. This was in the autumn of 1910. I was then asked to prescribe for him. On inquiry, he told me that his diet in the infirmary had consisted chiefly of salt fish and, having read at that time several articles on the effects of sodium chlorid in producing water retention in the tissues, I put him on a salt-free diet and on articles of food containing potash such as unsalted potatoes *ad libitum*, cereals and various vegetables. He also had milk and buttermilk, and was allowed the fat of bacon. The only medicine he had to take was the mistura alba (magnesium sulphate and magnesia) sufficient to keep his bowels in action, and occasional doses of potassium bicarbonate by the mouth. Before the end of three weeks he walked to my office unaided, a distance of more than half a mile, and told me he had lost over 6 inches around the waist, his legs and arms were much reduced in size and he felt much more comfortable. The urine was clearer and contained less albumin. In another month he began to do some work, and when I left London, in May, 1911, he was still able to work to earn his living. I heard of him a few months after I left and was told that he kept fairly well, but I have heard nothing more since.

I feel convinced that, in this instance, the continual aggravation of the dropsy was due to the ingestion of sodium chlorid from the salt fish of the food, and the rapid improvement of the symptoms to the sudden cutting off of the salt supply to the tissues, together with the elimination of sodium chlorid by the administration of potassium salts both as a medicine and in the diet.

It is not improbable, therefore, that the benefits obtained by the administration of Ringer's solution in these cases are due to the potassium contained in it and perhaps also to the calcium. I doubt that the sodium contained in Ringer's solution has any share in the benefits derived from its administration, except in so far as it may be converted, by the presence of potassium and calcium salts, into some other sodium salt having less power to produce water retention than the chlorid and thus be rendered more easy of elimination.

I am inclined to think also that chronic cases of dropsy offer a safer means of finally judging of the effect of sodium chlorid in producing edema than acute ones, because the latter present greater reactive and recuperative powers to overcome the effect of sodium chlorid, even if injurious, than the former. On the other hand, it must be borne in mind that when the elimination of the excessive sodium chlorid

is prolonged to a degree of salt starvation of the tissues, which require sodium chlorid as a normal constituent, an opposite condition may be developed which might produce a nephritis of a special character.

PAUL Z. HEBERT, M.D., New York.

Medical Education and State Boards of Registration

COMING EXAMINATIONS

ALABAMA: Montgomery, Jan. 5, 1915. Chairman, Dr. W. H. Sanders, Montgomery.

ALASKA: Juneau, Jan. 5, 1915. Sec., Dr. H. C. DeVighne, Juneau.

ARIZONA: Phoenix, Jan. 5-6, 1915. Sec., Dr. John Wix Thomas, 200 Nat'l Bank of Ariz. Bldg., Phoenix.

ILLINOIS: Chicago, Jan. 13-15, 1915. Sec., Dr. C. St. Clair Drake, Springfield.

INDIANA: Indianapolis, Jan. 12-14, 1915. Sec., Dr. W. T. Gott, State House, Indianapolis.

IOWA: Des Moines, Jan. 19-21, 1915. Sec., Dr. Guilford H. Sumner, Capitol Bldg., Des Moines.

MINNESOTA: Minneapolis, Jan. 5-8, 1915. Sec., Dr. Thomas McDavitt, 814 Lowry Bldg., St. Paul.

NEW HAMPSHIRE: Concord, December 29-30. Regent, Mr. H. C. Morrison, Concord.

NEW MEXICO: Santa Fe, Jan. 11, 1915. Sec., Dr. W. E. Kaser, E. Las Vegas.

NEW YORK: Albany, Buffalo, New York, Syracuse, Jan. 26-29, 1915. Mr. H. H. Horner, Chief, Examination Division, State Education Bldg., Albany.

NORTH DAKOTA: Grand Forks, Jan. 5, 1915. Sec., Dr. G. M. Williamson, Grand Forks.

OKLAHOMA: Oklahoma City, Jan. 12-14, 1915. Sec., Dr. John W. Duke, Guthrie.

RHODE ISLAND: Providence, Jan. 7, 1915. Sec., Dr. Gardner T. Swarts, State House, Providence.

SOUTH DAKOTA: Pierre, Jan. 12, 1915. Sec. Dr. P. B. Jenkins, Wauhay.

UTAH: Salt Lake City, Jan. 4-5, 1915. Sec., Dr. G. F. Harding, 407 Templeton Bldg., Salt Lake City.

VERMONT: Montpelier, Jan. 11-13, 1915. Sec., Dr. W. Scott Nay, Underhill.

WASHINGTON: Walla Walla, Jan. 5, 1915. Sec., Dr. C. N. Suttner, Baker Bldg., Walla Walla.

WISCONSIN: Madison, Jan. 12-14, 1915. Sec., Dr. John M. Beffel, 3200 Clybourn St., Milwaukee.

Alaska July Report

Dr. Harry C. DeVighne, secretary of the Alaska Board of Medical Examiners, reports the written examination held at Juneau, July 7-8, 1914. The total number of subjects examined in was 12; total number of questions asked, 66; percentage required to pass, 75. The total number of candidates examined was 4, all of whom passed. The following colleges were represented:

PASSED		
College	Year Grad.	Per Cent.
Rush Medical College	(1912)	82
Albany Medical College	(1912)	77.7
Jefferson Medical College	(1910)	75.5
McGill University	(1897)	75

Rhode Island July Report

Dr. Gardner T. Swarts, secretary of the Rhode Island State Board of Health, reports the practical and written examination held at Providence, July 2-3, 1914. The total number of subjects examined in was 7; total number of questions asked, 70; percentage required to pass, 80. The total number of candidates examined was 14, of whom 10 passed and 4 failed. The following colleges were represented:

PASSED		
College	Year Grad.	Per Cent.
University of Illinois	(1914)	80.7
University of Maryland	(1914)	81.7
Harvard University	(1910)	91
Tufts College Medical School	(1912) 90, 92.6; (1914)	84.9
Coll. of P. and S. in the City of N. Y.	(1895) 80; (1906)	86.9
Columbia University	(1911) 84.4; (1914)	86.7
FAILED		
Boston University	(1914)	75.5
Tufts College Medical School	(1905)	63.5
Medico-Chirurgical College of Philadelphia	(1914)	74.5
Meharry Medical College	(1914)	66.5

Miscellany

Harrison Bill Becomes A Law

During the last three years frequent mention has been made in THE JOURNAL of the efforts of Congress to enact a law for the control of traffic in habit-forming drugs. (April 18, 1911, p. 1276; Aug. 2, 1913, p. 360; Jan. 24, 1914, p. 316.) As has been previously stated, two of the three measures known as the Harrison bills were enacted at the last session of Congress. These provided for the regulation of the manufacture and importation of drug preparations containing opium or coca leaves or any of their compounds. The third bill, intended to regulate the interstate traffic in habit-forming drugs, presented difficulties which were not encountered in the other two measures. Congress has no power to enact regulations for the sale of any article within state boundary lines; the question whether or not it has the power to restrict trade in an article solely for the public good is one on which there is a diversity of opinion. Consequently the method resorted to in most restrictive measures of this class is to draft them under the guise of revenue measures and to regulate them through the levying of a tax. This method was followed in the Esch phosphorus bill by which Congress imposed such a heavy revenue tax on matches made with white phosphorus as practically to prohibit their sale as an article of common use. The same plan has been resorted to in the third Harrison bill. This bill, after lengthy discussion and considerable amendment, finally passed the House, June 26, 1913, and the Senate, Aug. 11, 1914. The differences between the amendments made in the House and the Senate were so great as to make it necessary to refer the measure to a conference committee. On October 17, the conference committee reported an agreement and the amended measure was adopted by the Senate, the House adjourning without action. Following the reassembling of Congress, the report of the conference committee was again taken up and on Thursday, December 10, the bill was finally passed by the House. On account of the great amount of discussion which has been excited by the bill and its interest to and effect on the medical profession, an abstract of the law is given herewith.

Explanation of the Bill

The title of the act is "An Act to provide for the registration of, with collectors of internal revenue, and to impose a special tax upon all persons who produce, import, manufacture, compound, deal in, dispense, sell, distribute or give away, opium or coca leaves, their salts, derivatives or preparations and for other purposes."

Section 1 provides that after March 1, 1915, every person who performs any of the acts mentioned in the title shall register with the collector of internal revenue of the district his name and place of business and shall pay a special tax of one dollar a year. Employees of registered persons, officers of the United States government, lawfully engaged in purchasing the drugs named for the army, navy, public health service or government hospitals and prisons are exempt. Only registered persons shall be permitted to perform any of the acts mentioned in the title. The term "person" is expressly defined to include partnerships, associations, companies or corporations.

Section 2 provides that no person shall sell, barter, exchange or give away any of the drugs mentioned except on a written order on a form issued by the Commissioner of Internal Revenue and supplied only to registered persons. Such orders shall be issued in duplicate, the original to be preserved by the person filling the order and the duplicate to be preserved by the person issuing it, for a period of two years and kept so as to be accessible to inspection by any officer of the treasury department or of state, territorial district and municipal officers. The exemptions under this section were the subject of the most prolonged discussion. As the bill finally passed, it provides that this section shall not apply to the dispensing or distribution of any of the drugs

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named, to a patient, by a physician, dentist or veterinary surgeon registered under the act in the course of his professional practice, provided that the physician, dentist or veterinary surgeon shall keep a record of all such drugs dispensed or distributed, showing the amount, the date and the name and address of the patient, except such as may be dispensed or distributed to a patient on whom such physician, dentist or veterinary surgeon shall personally attend. This record is to be kept for a period of two years, subject to inspection. The sale of any of the drugs mentioned, on a written prescription issued by a physician, dentist or veterinary surgeon, is also exempt but the person filling the prescription is required to keep the prescriptions on file for a period of two years. The sale of drugs to foreign countries is exempt, subject to the regulations of the country importing them, as is also the sale of drugs to any properly authorized government officer or state, territorial, district, county or municipal official purchasing supplies for a public hospital or prison.

The commissioner of revenue is authorized to prepare suitable blanks to be sold to dealers, the price not to exceed one dollar per hundred and the name of the purchaser using the blank is to be written or stamped on it by the collector of internal revenue. No other persons are permitted to use the forms. Special provisions are made for the administration of the act in Porto Rico, the Philippine Islands and the Canal Zone.

Section 3 provides that all persons registered under the provisions of the act shall, whenever required to do so by the collector of the district, make a full and correct statement on oath of the quantity of the drugs he has received and the names of the person from whom he has received them.

Section 4 prohibits any except registered persons from shipping or delivering any of the drugs mentioned in interstate commerce. Common carriers and employees are exempt.

Section 5 provides that duplicate orders and prescriptions shall be open to the inspection of all authorized agents of the treasury department and officers of any state, territory or municipality. Certified copies of such statements can be secured on the payment of a suitable fee. No persons are permitted to disclose the information contained in the returns except in the matter designated above. Copies of the names of all persons listed in any district may be secured on payment of one dollar for each one hundred names.

Section 6 provides that the act shall not apply to preparations or remedies which do not contain more than 2 grains of opium or more than ¼ grain of morphin or more than ⅛ grain of heroin or more than 1 grain of codein to the fluidounce or, in the case of solid preparations, to the avoirdupois ounce or to preparations for external use only or to decocainized coca leaves or other preparations of coca leaves which do not contain cocain.

Section 7 provides that all existing laws for the collection of internal revenue taxes are to be applied to the special taxes imposed by this act.

Section 8 provides that the possession of any of the drugs mentioned on the part of any unregistered person shall be regarded as presumptive evidence of the violation of the law. Employees of registered persons, nurses under the supervision of registered physicians, physicians themselves registered under the act, proper officials, warehouse men holding possession of goods for registered persons and common carriers transporting such goods are exempt.

Section 9 provides a penalty of not more than $2,000 fine or imprisonment for not more than five years or both for violations of the act.

Section 10 authorizes the commissioner of internal revenue to appoint such persons as may be necessary to carry out the provisions of the act.

Section 11 appropriates $150,000 to make the act effective and Section 12 provides that this act shall not be regarded as modifying the national Food and Drugs Act or the act of 1909, prohibiting the importation of opium.

Medicolegal

Compulsory Vaccination Compatible with Compulsory School Attendance

(People vs. Ehrold (N. Y.), 105 N. E. R. 670)

The Court of Appeals of New York affirms a judgment holding a father liable for the penalty provided by the education law for a failure to cause his son to attend on instruction notwithstanding the father made the defense that he did not believe in vaccination and the school authorities had refused to allow the child to attend school without being vaccinated. The court says that the question which within certain limits was presented here was whether the statute and the by-laws of the board of education in New York City adopted under and in accordance with the statute requiring vaccination as a condition of attending the public schools were under ordinary conditions so unusual or oppressive that a parent should be allowed to make his unwillingness to comply therewith a basis for not sending his children to school, for that was what the position of the defendant amounted to. The court does not think that they were of such a character. Under this court's decision in Re Viemeister, 179 N. Y. 235, it must assume that the law requiring vaccination of children in the public schools is a proper one. The statute requiring vaccination was adopted in its present form in 1893. The provision requiring attendance on instruction was first adopted in 1894. It does not seem reasonable to assume that it was the legislative intention in passing both of these statutes relating to attendance at school to provide and have it come to pass that the unwillingness to comply with the one requiring vaccination might be turned into a good excuse for disobeying the other one concerning attendance. It does not require much spirit of prophecy to foresee what would follow a contrary construction of the statutes. So far as the evidence disclosed, the defendant's refusal to comply with the requirements of attendance at school was arbitrary and capricious, and as one read the record and argument of his counsel the impression somehow arose that he was more interested in asserting his right to refuse to comply with the law than he was actuated by the purpose of protecting his child from some possible or supposed injury. Moreover, the vaccination statute under consideration applies only to the public schools, while it is well known that there are schools of other kinds and classes which might have been attended by the defendant's child where attendance would not have been subject to the condition which he urged as an excuse for his failure to send his child to school. It might or it might not be that that would entail expense, and even if it did it would not be sufficient to excuse the position and situation of the defendant. We are made well aware at the present day that the government in the exercise of its police powers does impose many regulations which involve trouble and expense, and such trouble and expense have not been regarded as an excuse for non-compliance.

Marriage of Drugged Physician to Nurse Annulled

(Waughop vs. Waughop (Wash.), 143 Pac. R. 444)

The Supreme Court of Washington affirms a judgment annulling the marriage in this case of a physician to a nurse, on account of the mental incapacity of the plaintiff at the time the marriage ceremony was performed. The court says that he was 46 years of age, and she 30 years of age. He had been for many years afflicted with insomnia, and had at times taken drugs in large quantities to overcome it. His mother, to whom he was greatly devoted, had been ill for some time, and he had been her physician and nurse. On Jan. 26, 1913, her condition was so alarming as to cause him great mental worry. Prior to that date he had casually met the defendant two or three times. On and after that date she visited his home daily, and after a day or two kept him at her sanitarium at night and gave him drugs and hot baths, as she said, to produce sleep. She claimed that they became engaged about January 30. He said that he had no recollection of either a courtship or engagement. She kept him

under her control until February 4. On the forenoon of that day they applied for a marriage license, which the auditor, at the suggestion of the plaintiff's friends, refused to issue. In the afternoon they met at the home of his pastor, where the plaintiff was examined by two physicians who agreed that he was not then mentally competent to enter into the marriage relation, owing to excessive use of drugs. But despite the advice of the physicians, the advice and protest of the pastor, and the earnest protest of the plaintiff's relatives, they procured a license at 11:30 that night and were married at midnight. They lived together at the sanitarium conducted by the defendant from February 4 until February 12, when the plaintiff left the defendant, and on the next day brought this action to annul the marriage. The court thinks that it was correctly decided that the plaintiff was mentally incompetent at the time of the marriage, and that the marriage was not validated by consummation or ratification. The law presumes sanity rather than insanity, and competency rather than incompetency. It follows that one who asserts his incompetency to enter into a contract, whether it be a contract of marriage or one of another nature, must establish his incompetency at the time the contract was entered into by clear and convincing evidence. It is equally well settled that, where one is induced to make a contract by the artifice or fraud of the other party to the contract, less evidence will suffice to annul it. If the plaintiff's incapacity was such that he was incapable of understanding the nature of the contract, incapable of understanding the obligations assumed by the marriage, or if he was in a state of mental bewilderment to the extent that he yielded without demur to the suggestion of the defendant and she procured the marriage to be entered into, he had a right to secure its annulment, unless he consummated or ratified it after his competency was restored, which he did not do.

Manslaughter in Failure to Provide for Child

(State vs. Staples (Minn.), 148 N. W. R. 283)

The Supreme Court of Minnesota holds that a parent who by culpable negligence fails to provide care, nurture, sustenance, and medical assistance to a child wholly incapable of supplying its own wants, and so causes its death, is guilty of manslaughter in the second degree, under the statute of that state which provides that the offense of manslaughter in the second degree is committed by the killing of a human being, when done without a design to effect death, "by any act, procurement, or culpable negligence . . . which . . . does not constitute the crime of murder in the first degree, nor manslaughter in the first degree." The allegations were sufficient in an indictment which charged that the defendant became the mother of a male child, that after its birth and on the same day she wilfully made an assault on said child, and by acts, procurements, and culpable negligence she did wilfully neglect to provide care, nurture, sustenance, and medical assistance and aid to preserve its life, but wholly neglected it, and that in consequence thereof the life of said child was shortened and it did languish and die, etc.

What Constitute Insane Delusions

(Coffey et al. vs. Miller et al. (Ky.), 169 S. W. R. 852)

The Court of Appeals of Kentucky says, in this will-contest case, that an insane delusion is an idea or belief which springs spontaneously from a diseased or perverted mind without reason or without foundation in fact. It is distinguishable from a belief which is founded on prejudice or aversion, no matter how unreasonable or unfounded the prejudice or aversion may be. If it is the product of a reasoning mind, no matter how slight the evidence on which it is based, it cannot be classed as an insane delusion. In everyday life men of the strongest minds, being in possession of the same facts, reach different conclusions. Here the maker of the will, being presumably in possession of at least as much knowledge about certain occurrences as his relatives and neighbors, reached a different conclusion as to who were responsible for them, and the fact that he reached a different conclusion from most of his relatives and neighbors did not make his belief an insane delusion.

Current Medical Literature

AMERICAN

Titles marked with an asterisk (*) are abstracted below.

American Journal of Diseases of Children, Chicago

December, VIII, No. 6, pp. 385-488

1 *Infantile Scurvy: The Blood, Blood-Vessels and the Diet. A. F. Hess and M. Fish, New York.
2 *Experimentally Produced Internal Hydrocephalus. W. E. Dandy and K. D. Blackfan, Baltimore.

1. **Infantile Scurvy.**—A study of the cause of the bleeding in infantile scurvy including a consideration of the clotting-power of the blood, forms the nucleus of the investigation made by Hess and Fish. For the coagulation tests blood was aspirated directly from the blood-vessels and oxalated. This plasma showed a slight diminution in clotting-power. This defect did not seem, however, to be the result of an insufficiency of calcium. The antithrombin was not increased. Small amounts of blood were also obtained by puncture of the finger. Examinations of this blood revealed a normal number of blood platelets. In other respects the picture was that of a simple secondary anemia, except that the hemoglobin was diminished out of proportion to the red blood-cells. A marked regeneration of these cells during convalescence, leading to a polycythemia, was also noticed.

These various departures from the norm according to the authors are insufficient to account for the hemorrhages associated with the disease. The integrity of the blood-vessels was therefore investigated. The vessels of normal infants were found to withstand, without apparent disturbance, 90 degrees of pressure for three minutes, whereas the vessels of infants suffering from scurvy gave way under this pressure. Numerous petechial hemorrhages of the skin or mucous membranes were frequently noted as one of the earliest signs of the disease. The well-known "exudative diathesis" of Czerny was found definitely to predispose to the development of scurvy.

Several cases of scurvy developed in infants who were being fed on milk which was pasteurized to 145 F. for thirty minutes. They were cured by receiving fruit-juices or raw milk. Orange-juice was found not to lose its efficacy as the result of being boiled for ten minutes. The juice of the peel was successfully substituted as an antiscorbutic for the juice of the orange. Potato proved to be an excellent antiscorbutic. It is suggested that it be added to pasteurized milk as potato-water instead of the barley-water which is now commonly used as a diluent. In this way the necessity will be obviated of giving orange-juice. Cod-liver oil or olive oil, although given for weeks, did not prevent the development of scurvy.

2. **Internal Hydrocephalus.**—An internal hydrocephalus was experimentally produced by Dandy and Blackfan in dogs by placing an obstruction in the aqueduct of Sylvius. It was made evident that the cerebrospinal fluid is formed in the ventricles faster than it can be absorbed, and that the aqueduct of Sylvius is essential for its escape. An internal hydrocephalus resulted from placing an obstruction in the aqueduct of Sylvius in spite of the extirpation of the choroid plexus of both lateral ventricles. An internal hydrocephalus may also result from an experimental ligation of the vena Galena magna near its origin; when the ligature is more distally placed or when the sinus rectus alone is ligated, an internal hydrocephalus does not result, owing to the efficient venous collateral circulation. Cerebrospinal fluid is derived mainly from the choroid plexuses, probably both by filtration and by secretion.

An increase of cerebrospinal fluid is caused by general venous congestion as demonstrated by temporary jugular compression. This increase of fluid ceases when the congestion is relieved by the collateral circulation. Drugs and glandular extracts produce but slight change in the rapidity of formation of cerebrospinal fluid. Pilocarpin produced a slight increase. There is a rapid constant formation and absorption of cerebrospinal fluid. A new supply is formed and absorbed at least every four to six hours. Cere-

brospinal fluid is absorbed directly into the blood from the entire subarachnoid space. It is a diffuse process. There is practically no absorption from the ventricles.

The maintenance of an equilibrium between the formation and the absorption of cerebrospinal fluid necessitates a communication between the ventricles and the subarachnoid space. Communication is solely by the foramina of Magendie and Luschka. After the introduction of phenolsulphonephthalein into the subarachnoid space it soon appears in the lateral ventricles. There are therefore no valves at these openings. If an obstruction exists at the aqueduct of Sylvius, phenolsulphonephthalein does not appear in the spinal fluid. The so-called foramina of Mierzejewsky and Bichat therefore do not exist.

In seven patients with internal hydrocephalus lack of communication was demonstrated clinically. In each of these seven cases there was practically no absorption from the ventricles, while the subarachnoid absorption was high. The internal hydrocephalus, therefore, resulted because the passage of fluid from the ventricles into the subarachnoid space was prevented. Four cases of internal hydrocephalus in which there was communication between the ventricles and the subarachnoid space were studied. In these cases there was a low subarachnoid absorption. Meningitis was the cause of the hydrocephalus in two patients with the obstructive type and two with the communicating type of hydrocephalus. The probable cause of internal hydrocephalus following the excision of a meningocele is the limitation of absorbing surface and consequent diminution in the absorption of cerebrospinal fluid.

The authors point out that surgical treatment differs according to the variety of internal hydrocephalus. In the obstructive type the obstruction must be removed. In the communicating type it is necessary to increase the area for the absorption of fluid.

Annals of Surgery, Philadelphia

December, LX, No. 6, pp. 665-818

3 *Biliary Surgery. J. F. Erdmann, New York.
4 *Case of Retention Cysts of Pancreas. J. Speese, Philadelphia.
5 Cystic Lymphangioma of Great Omentum. Report of Case. G. W. Outerbridge, Philadelphia.
6 Priapism; Report of Case and Study of Literature. F. Hinman, Baltimore.
7 *Rupture of Bladder. J. B. Clark, New York.
8 *Operative Treatment of Acute Epididymitis. D. O. Smith and B. H. Frayser, Ancon, C. Z.
9 Hydronephrosis. G. D. Stewart and W. H. Barber, New York.
10 Pyelography in Diagnosis of Traumatic Injury of Kidney. Report of Three Cases. W. H. Luckett and L. Friedman, New York.
11 Congenital Malformation of Posterior Urethra. O. S. Lowsley, New York.
12 Circulatory and Trophic Disturbances of Extremities. H. N. Collins, New York.
13 Cinematoplastic Amputations. Report of Two Cases. A. P. C. Ashhurst, Philadelphia.

3. **Biliary Surgery.**—An analysis of 270 cases operated on within a period of fifty-one months with 13 deaths is presented by Erdmann. His records show 54 cases of acute cholecystitis; 34 cases of gangrenous cholecystitis, and 115 cases of cholecystitis not otherwise classified—this series included all varieties, from non-inflammatory to hydrops. There were 6 cases of perforated cholecystitis; 6 non-calculous; 4 malignant, and 8 cases of hydrops; cholangeitis 23 cases. In addition, acute hemorrhagic pancreatitis, with suppuration or sloughing, was observed six times. The operations recorded were as follows: Cholecystostomy, 125 cases, with 5 deaths. Cholecystectomy, 96 cases, with 4 deaths. Choledochotomy and transduodenal choledochotomy, 5 cases in all with 2 deaths. Cholecystostomy, with choledochotomy, 17 cases, with one death. Cholecystectomy with choledochotomy, 27 cases, with one death. Cholecystotomy with and without combined operations on the duct, 142 cases with 6 deaths. Cholecystectomy, with and without combined operations on the ducts 123 cases with 5 deaths.

4. **Retention Cysts of Pancreas.**—Speese's patient, a male aged 59, noted a feeling of discomfort in the epigastrium six years ago, and at times suffered from pain which radiated from the epigastrium to the lower dorsal region. Coincident with the discomfort, he experienced a sensation of pulsation in the upper portion of the abdomen, and several months ago was able to palpate a mass in the midline above the umbilicus, in the situation in which the pulsation was present. The mass would disappear for a time, then reappear, and of late has been present only in the standing posture. He has lost about six pounds in weight and has had several attacks of jaundice.

Physical examination showed in the epigastrium a pulsating mass which seemed to blend with the abdominal aorta. There was no tenderness or rigidity. Gastric analysis: Free HCl, 0; total acidity, 20; trace of lactic acid; occult blood, 0. Microscopic examination showed much mucus, starch granules and a few Oppler-Boas bacilli. Urine examination negative. Blood: Hemoglobin, 60; red blood-cells, 3,800,000; white blood-cells, 9,900.

At operation the stomach, duodenum and gall-bladder were found to be normal. In the folds of the gastrohepatic omentum a cystic tumor was found, the contour was irregular and the mass was about the size of a large peach. On the posterior aspect it seemed to be in relation with the vena cava and adherent to the head of the pancreas, so that in removing it a thin layer of pancreatic tissue was carried away with the tumor. The rent left in the gastrohepatic omentum was closed with a purse-string suture, leaving a small opening for a drainage tube. The patient made an uninterrupted recovery and was discharged cured. The tumor was composed of numerous cysts, the largest of which measured 2 cm. in diameter, the lining is smooth, and the contents consist of a cloudy fluid. In the center of the tumor, and surrounded by the multiple cysts, is a dense mass of whitish tissue which has the consistency of cartilage and contains several points of calcification.

7. **Rupture of Bladder.**—A case of intraperitoneal rupture of the bladder is reported by Clark which was not operated on until twenty-four hours after the rupture. The rupture of an apparently healthy bladder occurred without any sign of history of direct injury to the organ. After a day of heavy drinking, the patient slipped and fell down four or five steps in a sitting posture. He was immediately nauseated and vomited the contents of his stomach. He then started to walk home, twenty blocks away, and though seized with severe abdominal pain, he was able to reach his home, undress and go to bed. After a sleepless night, due to continued abdominal distress, he rose dressed about noon and went to a hospital.

The patient was prepared for operation. The usual suprapubic exposure showed a bladder extraperitoneally intact. The abdominal cavity being opened, a considerable quantity of urine and blood-clots were mopped out. A jagged transverse rent in the roof of the bladder, easily admitting three fingers, was found. The rents were closed by three layers of catgut sutures, placed successively through mucous membrane, muscular and peritoneal coats. The abdominal cavity was then closed in the usual way, with a cigarette drain and a catheter retained in the bladder. The patient sustained practically no shock from the operation and the postoperative course was uneventful. The retention catheter was removed after eight days and the patient was catheterized for a period of three or four days after which he was able to pass his urine easily. He was out of bed on the fourteenth day, and on the nineteenth day after operation, he seemed perfectly well and strong.

8. **Operative Treatment of Acute Epididymitis.**—Smith and Frayser are of opinion that in acute epididymitis epididymotomy is the rational thing to do because it shortens the duration of the disease; relieves the severe, weakening, sickening pain at once, causes the temperature to fall and induration to disappear rapidly.

California State Journal of Medicine, San Francisco

December, XII, No. 12, pp. 479-520

14 *Case of Primary Sarcoma of Stomach Treated by Partial Gastrectomy. T. W. Huntington, San Francisco.
15 Bone Splinting in Vertebral Tuberculosis. H. M. Sherman and G. J. McChesney, San Francisco.

16 Infantile and Juvenile Tabes. H. Barkan, San Francisco.
17 Feeding in the First Month of Life. A. Brown, San Francisco.
18 Centralization of Public Health Administration. J. N. Force, Berkeley.
19 Points of Interest in Technic of Gastro-Enterostomy. P. S. Campiche, San Francisco.
20 Does a Relationship Exist Between Tuberculosis of Epididymis and Tuberculosis of Kidney? R. L. Rigdon, San Francisco.
21 Report of Two Cases of Hernia. J. J. A. Van Kaathoven, Los Angeles.
22 Mendelian Law and Its Relation to Inherited Conditions of the Eye. D. F. Church, Redlands.
23 Conservative Amputations of Lower Extremities. C. E. Phillips, Los Angeles.
24 Case of Abdominal Pregnancy. W. Himmelsbach, Watsonville.

14. Primary Sarcoma of Stomach Treated by Partial Gastrectomy.—Huntington's patient was a woman, aged 67. The main trouble seemed to have originated within a comparatively short interval extending over a period of six months, during which time her symptoms were not especially distressing. There was never any vomiting of food or evidences of hemorrhage in the stools. She suffered very little pain and only moderate distress, after the ingestion of solid food. Her appetite was fairly well maintained and her physical condition was such as not to attract attention, save in a general way. There was a notable drop in the patient's strength and vigor.

The feature of the case which seemed of special significance was the existence of tenderness on pressure at or near the pyloric region. This was constant, and on the increase during the past two months; pyloric insufficiency existed only in a comparatively moderate degree. There was, also, a slight loss of weight, six pounds in six months. The abdomen was opened through the inner border of the right rectus. On the stomach side of the pylorus there was a rounded mass about the size of a cherry lying apparently in the submucous and muscular coat of the viscus. Between the examining fingers, the peritoneum being tightly drawn over the mass, it presented a whitish uniformly globular tumor. It was distinctly hard and resistant. The lumen of the pylorus was definitely narrowed.

About one-fifth of the stomach and fully an inch of the duodenum were included in the resection. The divided ends of the stomach wall and the duodenum were enfolded and the suture lines reinforced. A formal posterior gastrojejunostomy was then completed. Patient left the hospital in splendid condition at the end of ten days. Section showed tumor to consist of very numerous, round, spindle-cells. Diagnosis: Fibrosarcoma of the stomach.

FOREIGN

Titles marked with an asterisk (*) are abstracted below. Single case reports and trials of new drugs are usually omitted.

British Medical Journal, London

November 28, II, No. 2813, pp. 909-952

1 War and Typhoid. W. Osler.
2 *Report on Gas Gangrene. A. A. Bowlby and S. Rowland.
3 Injuries to Bowel from Shell and Bullet Wounds. P. Lockhart-Mummery.
4 Leeches. A. E. Shipley.

2. Report on Gas Gangrene.—The following conclusions are drawn by Bowlby and Rowland from their observations of this condition. All tight bandages and especially those applied at the first field dressing should be avoided. Shell wounds are so often followed by so much interstitial hemorrhage that the part swells and the bandage rapidly becomes tighter and interferes with the circulation. Consequently many bandages require to be cut within a few hours of their application. In many cases the tension requires to be relieved by incisions and drainage, and the opportunity should be taken to wash the wounds thoroughly with an antiseptic. Hydrogen peroxid is one of the best. Great care should be taken to remove portions of clothing as these contain the infective agent. Shattered fragments of bone and pieces of shell or gravel should be taken out. Amputation may often be successfully performed through tissues made emphysematous by gas but not yet gangrenous.

The group of anaerobes causing gangrene are spore-bearers, and spores (especially of this group of anaerobes) are especially difficult to kill by any antiseptic solution or even by boiling. Consequently, in order to sterilize instruments and other things that have been infected, other measures are required. (a) Destruction of blankets and clothing soaked by the discharge. (b) Heating in an autoclave at a temperature of 120 centigrade. (c) Boiling for an hour in a solution of 1 in 20 phenol or lysol (1 in 10). The mud on the clothes of wounded soldiers is almost certainly infected, and care should be exercised to see that the area in which operations or dressing of wounds are performed should be kept free from possible contamination from such a source. When possible, it is advisable to isolate patients under treatment in hospitals, and this is all the more necessary on account of the bad smell which is inseparable from the condition.

Lancet, London

November, 28, II, No. 4761, pp. 1233-1286

5 Patient and Disease. D. Duckworth.
6 *Myeloid Sarcoma; Analysis of Fifty Cases. M. J. Stewart.
7 *Heart-Block in Acute Rheumatic Carditis. A. E. Naish and A. M. Kennedy.
8 Localization of Bullets and Shrapnel. W. Overend.

6. Myeloid Sarcoma.—In every one of the fifty cases recorded by Stewart the diagnosis was confirmed or made by microscopic examination of the tumor. Of the 50 cases, 35 are from the jaws, 11 from the long bones, and 4 from other situations. The situation in 26 out of the 35 jaw cases was: Upper jaw, 12; lower jaw, 13; both jaws, 1. The incidence in other bones was: Femur, 6 (4 lower end and 2 upper end); humerus, 3 (2 lower end and 1 upper end); metacarpal, 3; tibia, upper end, 1; radius, upper end, 1; and coccyx, 1.

Stewart concludes from analysis of these cases that myeloid sarcoma is locally malignant only and does not undergo dissemination. It is to be clearly distinguished, both clinically and pathologically, from malignant giant-cell sarcoma, in which death with visceral dissemination is the rule, even after the most radical operative treatment.

The histologic diagnosis is based on the morphologic characters of the giant-cells, especially as regards their nuclei. In myeloid sarcoma the latter are numerous, uniform, small, and without mitoses; in malignant giant-cell sarcoma they are few, sometimes single, irregular, and often very large, while mitotic figures are frequent. Stewart makes a strong plea for the conservative treatment of myeloid sarcoma. He advocates thorough curettage as the operation of choice in the first instance in suitable cases; failing this, a local resection of the growth. Amputation should be the last resort, and only after the failure of less radical measures. An accurate histologic investigation of the tumor is in all cases essential.

7. Heart-Block in Acute Rheumatic Carditis.—Naish and Kennedy report two cases of heart-block which occurred in the course of acute rheumatic carditis in children and were associated with similar histologic changes in the cardiac musculature.

Berliner klinische Wochenschrift

November 9, LI, No. 45, pp. 1781-1804

9 Gunshot Wounds of the Stomach. (Perforierende Schussverletzungen des Magens.) Adler.
10 *Tetanus. H. Mühsam.
11 Gunshot Wound of Spinal Cord. (Rückenmarksverletzung.) E. Froehlich.
12 *Treatment of War Wounds of the Eyes. (Die Kriegschirurgie des Sehorgans.) K. Steindorff.
13 *The Symptoms of Brown-Séquard's Paralysis. M. Bernhardt.
14 *Renal Diabetes. C. D. de Langen.
15 Factors in Hernia of the Diaphragm. (Zur Entstehung der Hernia diaphragmatica und Dilatation des Zwerchfells.) F. Fidler.

10. Tetanus.—Mühsam remarks that other germs which get into the wound with the tetanus bacilli use up the oxygen and thus favor the anaerobic proliferation of the tetanus bacilli. Another favoring factor is the demoralization of the circulation in the injured tissues in the depths of the wound. The toxins generated may diffuse through the devitalized tissue into sound tissue until they reach a nerve. The practical

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inference is to clear out all devitalized tissue and saprophytes, etc., liable to use up the oxygen, and, last, but not least, to flood the depths of the wound with oxygen in addition to the routine treatment with antitetanus serum and sedatives as indicated. Hydrogen dioxid is another important aid in treatment. It may be necessary to make a breach in the teeth, when the jaws are locked together, so that the patient can expectorate. From lack of any gap in the teeth he lost a patient from aspiration pneumonia as the man was unable to spit although his condition otherwise was not so serious. Local warmth sometimes aids in the subsidence of the trismus.

12. **Injuries of the Eyes in War.**—Steindorff cites the statistics in this line from the wars of the last seventy years and discusses the management of cases of the kind.

13. **Brown-Séquard's Paralysis.**—The patient whose case is described is a man of 45 who has been under observation for six years. The disturbances have never been severe enough to interfere with his work as a railroad employe. The Wassermann test was positive and the motor symptoms improved under specific treatment but the sensory disturbances were not influenced. The syphilitic nature of the trouble is confirmed by symptoms which indicate three distinct foci in the left spinal cord, although there was no history of known syphilis and the man's wife and two children are healthy.

14. **Renal Diabetes.**—This article has already been reviewed in THE JOURNAL, Feb. 28, 1914, p. 739.

Deutsche medizinische Wochenschrift, Berlin

November 5, XL, No. 45, pp. 1929-1952

16 **Sepsis from Wounds in War.** (Wundinfektionskrankheiten.) G. Jochmann.
17 **Three Cases of Wounds from Alleged Dumdum Bullets.** (Bis zum 20. Oktober behandelte Dum-Dum-Verletzungen aus dem gegenwärtigen Kriege.) W. Pöppelmann.
18 **Diarrhea of Gastric Origin.** (Ueber gastrogene Diarrhoen und das Vorkommen von Achylia pancreatica bei Achylia gastrica.) A. Bittorf.
19 **The State and the Food Supply.** (Der Staat und die Volksernährung.) M. Rubner.
20 **Diagnosis of Typhoid and Cholera in the Field Laboratory.** M. Christian.

Medizinische Klinik, Berlin

November 8, X, No. 45, pp. 1653-1678

21 **Prophylaxis and Treatment of Bubonic Plague.** (Pest.) R. Poch.
22 **War Wounds of Peripheral Nerves.** (Kriegsverletzungen des peripherischen Nervensystems.) O. Hezel.
23 *Nature and Treatment of Psoriasis. (Schuppenflechte.) B. Spiethoff.
24 **Connection between Instability of the Vagus System and Seasickness.** (Ueber die Korrelation der Vagotonie zur Seekrankheit.) B. O. Pribram.

23. **Psoriasis.**—Spiethoff discusses the various theories that have been advanced in regard to the origin of psoriasis, but does not think that any of them have conclusive weight. An inherited tendency seems evident in about 5 or 6 per cent. of the cases, and anything causing internal disturbances is liable to aggravate the condition or bring on attacks, especially digestive disturbances, abuse of coffee, tobacco or alcohol, a diet too rich in albumin, or constitutional disease. One of his most inveterate cases of psoriasis was in a man with exophthalmic goiter. In another case so severe that the scalp and ears were covered with crusts, tests of the stomach functioning revealed anacidity. When diabetes and glycosuria can be excluded, benefit is often derived from a vegetarian diet. As to symptomatic measures, he does not rank any very high except Roentgen exposures. These are peculiarly effectual in the old cases with tough infiltrations on the limbs and head. Among the internal remedies he thinks that arsenic seems to be the only one that is worth mentioning; he has never seen any effect from salvarsan. Patients with severe psoriasis, taking a course of salvarsan for syphilis, did not find that the medication had any influence on the psoriasis. Serotherapy is inconstant in its action, but he extols the benefit from venesection in cases with much itching. Withdrawing from 50 to 100 c.c. of blood, repeating this two days later, generally put an end to the itching in his experience with it.

Münchener medizinische Wochenschrift, Munich

November 10, LXI, No. 45, pp. 2197-2232

25 *Localization of Foreign Bodies. (Fremdkörperlokalisation.) G. Holzknecht.
26 Technic for Serodiagnosis. (Zur Methodik des Abderhaldenschen Dialysierverfahrens.) H. Nieden.
27 *Varnish in Treatment of Wounds. (Welche Harzlösungen sind für Verbandzwecke geeignet?) K. Dieterich.
28 *The Work at a Base Hospital. (Der Betrieb eines Reservelazarettes.) H. Schridde.
29 Physical Bases of Radium Therapy. Kohlrausch. Commenced in No. 44.
30 *Gaseous Gangrene and Phlegmons. (Gasgangrän: einige Fälle von Gasphlegmonen.) E. Fraenkel and K. Franke.
31 Gunshot Wounds of the Spinal Cord. (Schussverletzungen des Rückenmarks.) N. Guleke.
32 Foot-Pump Apparatus for Local Anesthesia. (Pneumatische Lokalanästhesie.) F. Kuhn.
33 *Danger of Anaphylaxis from Antitetanus Serum. (Die Anaphylaxiegefahr bei der Serumbehandlung des Tetanus.) L. Simon.
34 *Intraspinal Magnesium Sulphate Treatment of Tetanus; Eight Cases. K. W. Ennike.
35 *Antitetanus Serum Plus Large Doses of Chloral in Tetanus. (Zur Behandlung des Wundstarrkrampfs.) A. Angerer.
36 Shell Wounds of the Bladder. (Zwei Blasenverletzungen durch Schrapnellkugeln.) Pitzner. (Spontaner Abgang eines in die Harnblase gedrungenen Granatsplitters.) H. Nohiling.
37 Typhus and Relapsing Fever. (Ueber Fleckfieber und Rückfallfieber.) Mühlens. Commenced in No. 44.

25. **Localization of Foreign Bodies with the Roentgen Rays.**—Holzknecht gives an illustrated description of the various technics best adapted to locate foreign bodies in the skull, limbs and trunk. He emphasizes the importance of heeding the geometrical principles involved.

27. **Varnish for Dressing Wounds.**—In the Balkan wars and in the present war extensive use has been made of a varnish applied around the wound as this fastens in all germs and the wound is thus saved from contamination from the environment. Another advantage is that the dressing sticks to the varnish and is thus held better in place. Opinions differ as to the value of varnish treatment, some lauding it and others finding it inconvenient. Dieterich says that if a varnish is to be used, dammar, colophonium and turpentine are just as good for the purpose as the more expensive resins, and they can be dissolved in benzol instead of chloroform, the cost thus being only a small fraction of that of ordinary varnish. He gives some formulas for a good inexpensive varnish of a neutral reaction, and thus non-irritating. One formula calls for 250 gm. dammar; 30 gm. castor oil or linseed oil; 700 gm. benzol; 50 gm. sodium bicarbonate and 5 drops of amyl acetate (*Birnenäther*). These ingredients are shaken up together repeatedly as they are kept at room-temperature for several days. Then the mixture is filtered, adding a little more of the solvent if any has evaporated. A few drops of the amyl acetate are then added to the mixture, when it is ready for use. Another formula is a mixture of 300 gm. light colophony; 20 gm. Venetian turpentine; 10 gm. castor or linseed oil; 700 gm. benzol, 60 gm. sodium bicarbonate and a few drops of amyl acetate.

28. **The Base Hospital.**—Schridde mentions a number of practical points he has learned in his service at Dortmund in which large numbers of sick and wounded soldiers have been received. With a special ward for skin and venereal diseases the men are cured much quicker than in the mixed wards and his special ward is always crowded. Experience has also confirmed the advantages of keeping the military and the civilian sick separate. He states that prisoners are treated in every respect the same as the other inmates of the hospital except that they are not given reading matter, games, tobacco or dainties sent in from outside; they are not allowed to leave their ward, and no visits are permitted from outsiders. The hospital also takes women in training for Red Cross nursing, rejecting all those who do not seem strong and well or who have much disturbance at menstruation.

30. **Gaseous Gangrene.**—Fraenkel says that when there is no superposed infection the gaseous gangrene is not accompanied by suppuration. It is in fact a malignant emphysema. It can be differentiated from malignant edema in twelve or eighteen hours by inoculation of animals, the guinea-pig for

gas-gangrene, the rabbit for malignant edema, the rabbit being apparently completely refractory to the germ of gas-gangrene. Staining a smear with a diluted solution of carbol-fuchsin will show the gas bacillus with its rounded ends, instead of the beveled ends of the anthrax bacillus, and its short thick shape distinguishes it from the slender bacillus of malignant edema. The bacillus of gas-gangrene is strictly anaerobic, and consequently treatment must aim to admit air freely to check its growth. Ample incisions and playing a jet of oxygen on the tissues, with extensive use of hydrogen peroxid, are the main reliance. If these fail, amputation may save the rest of the body. No serotherapy or internal measures have yet proved of use, but the patient's strength must be kept up.

Franke relates that in his six cases of gaseous phlegmon it developed several days after a shell wound in the leg. The onset was sudden and stormy, the limb became painful and discolored, the symptoms and aspect resembling those of acute and rapidly progressing venous thrombosis except for the accumulating gas. The zone of demarcation was more painful on pressure than the peripheral region. Amputation was the only recourse in four cases, and it came in time in two. In the two others the trunk was already involved and the patients seemed doomed, but one was saved by exarticulation of the thigh; the emphysema in abdomen and chest then promptly subsided. The other patient was febrile and did not survive the operation.

33. **Anaphylaxis from Antitetanus Serum.**—Simon had four rapidly fatal cases of tetanus among the 700 wounded in his service during four weeks. Then came a series of four mild cases with recovery under antitetanus serum treatment. In two other cases tetanus developed soon after a shell injury of the upper arm. One man was given 200 antitetanus serum units, both intravenous and intraspinal, repeated the next day and followed daily with 100 units intravenously after the arm had been amputated. He was progressing favorably until the intravenous injection the fourteenth day was followed by signs of severe anaphylaxis. Under stimulants in an hour he recuperated. The next day he developed an exanthem. No further antitoxin was given and in a few days all traces of the tetanus had vanished. In the other case there was some twitching in the arm and face but as this subsided after intravenous injection of 300 units, the assumption of tetanus seemed to have been erroneous. Thirteen days later the symptoms returned in a severe form and the intravenous injection of 300 units was repeated. It was followed in a few minutes by cyanosis, a chill and temperature of 40.9 C., but the pulse kept good. After this partial shock had subsided there was no return of the symptoms of tetanus. Three days later, the seventeenth day after the first injection, 100 units were injected intravenously again, and this time a typical severe anaphylactic shock ensued at once, with total unconsciousness for half an hour and marbling of the body, the pulse scarcely perceptible, and finally a chill and temperature of 40.1 C. The recovery from the shock was rapid and complete in both cases. By the next day the pulse and breathing were normal and the men felt none the worse for it. These cases suggest that the tenth day seems to be the danger line. In a more recent case, after the patient had been given 1,000 units of the serum in the course of ten days, Simon changed to magnesium sulphate, injecting subcutaneously every day from 40 to 60 c.c. of a 25 per cent. solution. This patient is now practically cured.

34. **Treatment of Tetanus.**—Eunike reiterates that magnesium sulphate treatment is only symptomatic, and that antitetanus serum should never be neglected in treatment. In his eight cases, the five with the most serious syndrome were not influenced by the drug. In the other cases great benefit was apparent although the tetanus was of a severe type. The sulphate was given by intradural injection of 10 c.c. of a 10 per cent. solution; a second dose of 8 c.c. was given three days later as symptoms returned. Disturbances in hearing and hallucinations followed one of the injections in each case, but the tetanus was materially relieved in both after each injection.

35. **Tetanus.**—Angerer extols the excellent results he has had recently in the twenty-four cases of tetanus in his service treated by antitetanus serum plus 5 gm. of chloral in an enema twice a day, or 10 gm. once a day, supplemented by one or two doses of 0.01 gm. morphin. By this means the patient is kept drowsy, in a kind of twilight sleep, and thus is spared all nervous shocks from without. The results have been very encouraging. He has discarded magnesium sulphate as his experiences with it were very unfavorable. He keeps up the antitetanus serum, 100 units both intraspinally and subcutaneously, until the symptoms show a turn for the better—the amounts thus totaling from 300 to 1,600 units.

Riforma Medica, Naples

October 17, XXX, No. 42, pp. 1149-1176

38 Experimental and Clinical Study of Biologic and Therapeutic Action of Benzol, Selenium, Tellurium and Thorium. (Azione di alcune sostanze sul sangue ed organi emopoietici.) C. Martelli.

October 31, No. 44, pp. 1205-1232

39 Fatigue Toxins as Factor in Immunity. (Il valore delle kenotossine nei processi d'immunita.) V. Palmulli.

40 *The Pituitary Body in Pregnancy. (Ipofisi e gravidanza.) U. Scinicariello.

41 Serovaccine Therapy in Tuberculosis. (Il trattamento Bruschettini nella cura della tuberculosi.) A. Cadani and A. Carafoli.

40. **Experimental Research on the Pituitary Body.**—Scinicariello thinks he is justified in affirming on the basis of his research on three dogs and a bitch, that the pituitary body is not a vitally indispensable organ and that its destruction *in situ* does not entail psychic disturbances if there are no other lesions, tumors, etc., to compromise the functioning of the brain. After destruction of the hypophysis no motor or sensory disturbances were observed, no macroscopic changes in the shafts of the long bones, nor any tendency to obesity. As late as four months after the destruction of the pituitary body, one bitch conceived and bore an apparently normal litter; delivery proceeded apparently physiologically although the hypophysis was supposedly entirely destroyed and no trace of it was found post mortem.

Hygiea, Stockholm

LXXVI, No. 20, pp. 1137-1199

42 *Spontaneous Subarachnoidal Hemorrhage. (Spontana subarachnoidalblödningens patologi och diagnostik.) A. Forsheim.

42. **Spontaneous Hemorrhage in the Subarachnoidal Cavity.**—In Forsheim's first case the patient was a previously healthy woman of 20 who was taken suddenly with symptoms suggesting acute spinal meningitis. The attack was like an apoplectic stroke, the patient falling but not losing consciousness, complaining of intense headache and pain in the spine. She vomited several times and lay with her head thrown back, the pain in the back of the neck increasing when it was straightened. The Kernig-Lasègue signs were positive alike on both sides. There was no nystagmus nor paresis; the diagnosis of subarachnoid hemorrhage was made at once and ice was applied to the head and spine and calcium chlorid and acetyl salicylic acid were given. The next day lumbar puncture released blood-stained cerebrospinal fluid under very high pressure (330 mm.) and the patient was relieved immediately. The proportion of reds and whites was about the same as in the blood and there were no clots. Lumbar puncture the following day showed still a pressure of 220 mm. but it dropped to 120 mm. after withdrawal of 20 c.c. Continued improvement followed, the temperature dropped to normal the fourth day after the second puncture and recovery was soon complete. The hemorrhage occurred while she was pumping water. The second patient was a youth of 17 and nine lumbar punctures were required. The onset and course were the same as in the first case. The fluid was under 450 mm. pressure at first, the pulse 60. The pressure kept high, over 300 mm. during the period of the first seven lumbar punctures, but there did not seem to be any additional hemorrhage after the first. Both patients recovered completely. Forsheim warns of the necessity for recording the pressure in the fluid, not allowing it to drop too low during the procedure, and repeating it at need.

Book Notices

A TEXT-BOOK OF THE DISEASES OF THE NOSE AND THROAT. By Jonathan Wright, M.D., Director of the Department of Laboratories, New York Post-Graduate Medical School, and Harmon Smith, M.D., Surgeon to the Throat Department of the Manhattan Eye, Ear, Nose and Throat Hospital. Cloth. Price, $5 net. Pp. 683, with 327 illustrations. Philadelphia: Lea & Febiger, 1914.

Any work fathered by this well-known pathologist must command the respect of the profession, and those who are familiar with the clear, carefully prepared articles of the gifted secretary of the American Laryngological Association will necessarily be attracted by this greater work. It is largely devoted to the etiology and pathology of the diseases of which it treats, but the symptomatology and diagnosis, the topical and operative treatment of the diseases of the upper air passages have not been neglected. The work is comprehensive and yet fairly concise, and goes directly to the point without tiring the reader with a mass of speculation and unproved theory. The equipment and methods of examination are well described in the first chapter. The second chapter is devoted to the embryology and anatomy of the nose, its external deformities and their correction. The third chapter considers the anatomy, histology and physiology of the internal nose, thus furnishing a foundation on which the student may build a consistent system of diagnosis and treatment of the numerous abnormal conditions of this region. The anatomy, embryology and histology of the pharynx and larynx each have a separate chapter. The numerous diseases of these parts have all been carefully considered and treated in a manner especially adapted for the practitioner who wishes to know, and for the student trying to learn. The book is admirably illustrated and is arranged for quick and accurate reference by the man in active practice, which gives it especial value; but it also is peculiarly adapted to the needs of students who have not had experience in this field.

TECHNIC DER SPEZIELLEN KLINISCHEN UNTERSUCHUNGSMETHODEN. Herausgegeben von Prof. Dr. Theodor Brugsch, 1 Assistent der II Medizinischen, und Prof. Alfred Schittenhelm, Direktor der Medizinischen Universitätsklinik in Königsberg. Second edition, Parts 1 and 2. Paper. Price, 36 marks. Pp. 1078, with 476 illustrations. Berlin: Urban & Schwarzenberg, 1914.

These two volumes form the second part of the authors' "Lehrbuch klinischer Untersuchungsmethoden," the first part of which appeared a few years ago. In this section have been grouped the special laboratory methods, which are such valuable adjuncts to the more direct clinical examination of the patient. The subject-matter of these volumes is varied, covering pathologic, bacteriologic, serologic and chemical methods which may be employed in the effort to reach an accurate diagnosis. The work is entitled to rank with the older one of Sahli, which has so long been regarded as the most authoritative one on the subject. Although these volumes do not take the place of those dealing with special fields of laboratory diagnosis, yet they may be recommended to the student and laboratory worker as a reliable and fairly comprehensive guide.

THE MEDICAL RECORD VISITING LIST OR PHYSICIAN'S DIARY FOR 1915. Leather. Price, $1.50. New York: William Wood & Co., 1914.

PRACTITIONER'S VISITING LIST FOR 1915. Leather. Price, $1.25 net. Philadelphia: Lea and Febiger.

THE PHYSICIAN'S VISITING LIST FOR 1915. Leather. Price, $1.25. Philadelphia: P. Blakiston's Son & Co., 1914.

The visiting lists for 1915 follow in general the style adopted in previous years. The make-up is the same as to arrangement of pages and sections for memoranda.

The Medical Record Visiting List contains a calendar, obstetric table, table of approximate equivalents, dosages, a list of solutions for subcutaneous injection and for atomization and inhalation, some miscellaneous hints, information on the treatment of poisoning and emergencies, artificial respiration, signs of death, and hints on the writings of wills.

The Practitioner's Visiting List gives information on dentition, a note on estimating the date of confinement, comparative scales of weights and measures, a section on the examination of the urine, a table of incompatibilities, a note on artificial respiration, a table of the eruptive fevers, a list of poisons and antidotes, a table of doses given in apothecaries' and metric systems, and a list of therapeutic reminders similar to that published in various handbooks issued by drug houses. Finally there is an article on the ligation of arteries.

The Physician's Visiting List is issued for various numbers of patients. It contains a calendar, a table for calculating the period of uterogestation, an article on incompatibilities, the treatment of poisoning, tables of weights and measures, a dosage table which gives official and unofficial drugs in both apothecaries' and metric systems, a table of quarantine periods in infectious diseases, an article on the treatment of asphyxia and apnea, and a comparison of the thermometric scales.

THE CANCER PROBLEM. By William Seaman Bainbridge, A. M., Sc.D., M.D., Professor of Surgery, New York Polyclinic Medical School and Hospital. Cloth. Price, $4 net. Pp. 534, with 38 illustrations. New York: The Macmillan Company, 1914.

The purpose of this book is to give in succinct form such a summary of the knowledge concerning cancer as may be of value to the general practitioner, the specialist, the intelligent layman and the lecturer on health matters. There are fourteen sections: on history, the major part being devoted to the history of modern cancer research; general distribution, botanical, zoological, geographical and ethnologic; statistical considerations; etiology; histopathology; cancer research—a summary of the world's work; clinical course; prophylaxis; investigation of cancer cures; non-surgical treatment; surgical treatment; irremovable cancer; institutions for the care of cancer patients, and on the campaign of education. This enumeration indicates that every phase of the cancer problem receives consideration, and it must be said that the object of giving a dependable summary of our knowledge of cancer for the large circle of readers has been accomplished with success. The various theories are stated clearly, the statements of facts are reliable, the practical deductions are sound, and an attitude of openmindedness is maintained in regard to all open questions. Being a fluent writer, the author often uses many more words than necessary, and quite a little detail has been introduced that is of no particular value in a book of this nature; but on the whole he has acquitted himself of the difficult task with credit.

THE PHARMACY HANDBOOK. By F. W. Crossley-Holland, F.C.S. Cloth. Price, $2. Pp. 224. New York: Oxford University Press, 1914.

The chief aim of this book is to present ready reference to information on matters which come within the purview of the practicing pharmacist. It is not a systematic treatise on pharmacy, but includes such incidental matters as the relations of the pharmacist to the physician, the trend of therapeutics, facts with reference to the newer therapeutic remedies, some of the principles of dietetics, etc. A special chapter is given to bacteriology, another to incompatibility and one to the ethics of pharmacy. In this chapter the author discusses the ownership of the prescription in which he states that custom and the patient have settled the matter, and the prescription seems unquestionably to belong to the patient. On the other hand, he states that the pharmacists's copy belongs to the pharmacist alone.

THE FECES OF CHILDREN AND ADULTS. Their Examination and Diagnostic Significance with Indications for Treatment. By P. J. Cammidge, M.D. Cloth. Price, $5 net. Pp. 516, with 109 illustrations. New York: William Wood & Co., 1914.

This new book of Cammidge makes extensive use of Hecht's "Die Faeces des Säuglings und des Kindes" as well as of Schmidt and Strasburger's "Die Faeces des Menschen," although much original matter is also included. The practical part of the book follows as far as possible the sequence in which routine examinations are usually made, namely, macroscopic examination, microscopic examination for general food and other residues, parasites and their ova, as well as for various bacteria, and, lastly, the chemical exami-

nation. Chapter IX, dealing with the diagnostic value of examinations of the feces, is especially valuable and worthy of mention. Chapter X discusses the indications for the treatment of abnormalities found. The subject-matter is well selected and arranged; the text is clear and concise; the methods of examination are the most satisfactory at our disposal. The illustrations are excellent. Cammidge rightly points out that "it is essential, for the greatest advantage to accrue to the patient, that the pathologist should be aware of the clinical signs and symptoms, so that he may arrange his investigations accordingly." The results of these investigations should be interpreted by the examiner only in consultation with the clinician. This book may be regarded as the most authoritative in the English language and should lead to the more frequent examination of the feces as well as to a better understanding of such examinations when made. We earnestly recommend this book to all practitioners, especially to those who may wish to have their fecal examinations made by others and who may desire a fuller knowledge of the proper interpretation of such examinations.

Pathogenic Micro-Organisms. A Practical Manual for Students, Physicians and Health Officers. By William Hallock Park, M.D., Professor of Bacteriology, University and Bellevue Hospital Medical College, and Anna W. Williams, M.D., Assistant Director of the Bureau of Laboratories, New York. Fifth Edition. Cloth. Price, $4 net. Pp. 684, with 219 illustrations. Philadelphia: Lea & Febiger, 1914.

In this edition of the well-known book of Park and Williams the material has been rearranged in order to bring more closely together all of the pathogenic organisms. Part I deals with the general characteristics and methods of study of all the micro-organisms considered (molds, yeasts, bacteria and protozoa); Part II includes the study of the individual pathogenic organisms, while Part III presents certain practical aspects of the subject under the title "Applied Microbiology." The subject of immunity has been extensively discussed. A new chapter on filterable viruses has been inserted. This is one of the most practical books at the disposal of the general or special worker, although not so extensive as some. The sections on technic are much more exhaustive than are usually found in general works on bacteriology, while the subject-matter is written with direct appeal to the physician and health officer. The enormous practical experience of the writers in the laboratories of the New York Health Department lends strength to the statements given as well as to the selection of methods advocated. The book may be unhesitatingly recommended to all workers who have occasion to resort to bacteriologic methods in their investigations.

Morris' Human Anatomy. A Complete Systematic Treatise by English and American Authors. Edited by C. M. Jackson, M.S., M.D., Professor of Anatomy, University of Minnesota. Fifth edition. Cloth. Price, $6 net. Pp. 1539, with 1,182 illustrations. Philadelphia. P. Blakiston's Son & Co., 1914.

This edition of this standard work includes many new illustrations and a few changes in arrangement. There is a good thumb index, which aids in the usefulness of such large books as our modern anatomies have come to be. An interesting feature is the reproduction of serial roentgenograms of the stomach. Needless to state, the Basle anatomic nomenclature is used throughout, the previous edition of this book being the first general text-book in anatomy in English to adopt the now generally used terminology.

A Text-Book of Physiological Chemistry. By Olof Hammarsten, Emeritus Professor of Medical and Physiological Chemistry in the University of Upsala. With the Collaboration of S. G. Hedin, Professor of Medical and Physiological Chemistry in the University of Upsala. Authorized translation from the Eighth German Edition by John A. Mandel, Sc.D., Professor of Chemistry in the New York University and Bellevue Hospital Medical College. Seventh edition. Cloth. Price, $4 net. Pp. 1026. New York: John Wiley & Sons, 1914.

"At this time, when so many new and important biochemical facts are being published and when so many older theories and deductions are found more or less erroneous, due to recent investigations using new methods," it is very fortunate that we have been given this complete and critical compilation by Professor Hammarsten. In the work of revision, Professor Hedin has aided considerably by taking care of many of the chapters dealing with subjects with which his own work has been closely identified. This work does not lend itself to a close review, as the subject-matter is too extensive and too diversified. The work stands as the most authoritative one on this subject, so that we must thank Professor Mandel for his careful and excellent translation. The book is recommended both to the student and the advanced worker as a mine of information on the various phases of physiologic chemistry.

A Manual of Bacteriology, Clinical and Applied. By R. Tanner Hewlett, M.D., F.R.C.P., D.P.H., Professor of Bacteriology in the University of London. Fifth edition. Cloth. Price, $4.50. Pp. 668, with illustrations. St. Louis: C. V. Mosby Company, 1914.

The text in this edition of Hewlett's book has been revised, and many alterations and additions have been made in the preliminary chapters dealing with the structure and classification of micro-organisms and with the methods of cultivation, isolation and staining. The portions treating of the specific organisms have, for the most part, been enlarged, while much new matter dealing with the protozoa has been inserted. The theoretical parts of the book have been considerably augmented. The text is clear and concise; the subject-matter is well selected; the methods of diagnosis, while not exhaustive, are adequate for general work, and the general make-up of the work is satisfactory. The book is to be recommended to the student as well as to the general practitioner who may wish to become more familiar with this field of medical science.

A Practical Medical Dictionary of Words Used in Medicine. With Their Derivation and Pronunciation, Including Dental, Veterinary, Chemical, Botanical, Electrical, Life Insurance and Other Special Terms; Anatomical Tables of the Titles in General Use and Those Sanctioned by the Basle Anatomical Convention; Pharmaceutical Preparations, Official in the U. S. and British Pharmacopeias and Contained in the National Formulary; Chemical and Therapeutic Information as to Mineral Springs of America and Europe and Comprehensive Lists of Synonyms. By Thomas Lathrop Stedman, A.M., M.D. Third edition. Leather. Price, $5 net. Pp. 1037, with illustrations. New York: William Wood & Co., 1914.

This edition is larger by thirty pages than the previous one, and new plates have been made for the whole book. It has been brought up to date by the incorporation of a large number of new terms which have come into medical literature since the former issue.

Heredity and Sex. By Thomas Hunt Morgan, Ph.D., Professor of Experimental Zoology, Columbia University. Cloth. Price, $1.75 net. Pp. 282, with 121 illustrations. New York: Columbia University Press, 1913.

This book consists of the Columbia University Jesup Lectures for 1913. The newest researches are included, and the author correlates the study of heredity with the study of the changes in the germ cell. The work includes chapters on the evolution of sex; mechanism of sex determination; Mendelian principles; secondary sexual characters; effects of castration and transplantation; gynandromorphism, hermaphroditism, parthenogenesis and sex; fertility and special cases of sex inheritance. There is a well-chosen bibliography to complete a book which is succinct, nicely printed and well illustrated.

The Infant—Nutrition and Management. By Eric Pritchard, M. A., M.D., M.R.C.P., Physician to the Queen's Hospital for Children, London. Cloth. Price, $1 net. Pp. 265. New York: Longmans, Green & Co., 1914.

The author has here collected lectures delivered at sundry times and places on such subjects as the establishment of lactation and management of breast feeding, physiologic principles concerned in the nutrition and the quantitative food requirements of infants, training of the nerve centers, constipation and its treatment with petrolatum, convulsions, rickets, etc. It fairly well covers the general principles of the subject, and in a way that in many instances is quite at variance with orthodox views. As a book it has the defects of the diffuse style of the lecture and many repetitions, for which the author makes apology.

JOURNALS INDEXED IN THE CURRENT MEDICAL LITERATURE DEPARTMENT JULY-DECEMBER, 1914

The following journals have been indexed in the Current Literature Department of THE JOURNAL during the past six months. Any of the foreign journals, except those starred, will be lent by THE JOURNAL to subscribers in the United States and to Fellows of the American Medical Association for a period not exceeding three days. Only one journal may be borrowed at a time. Requests for periodicals should be addressed to the Library of the American Medical Association and six cents in stamps should be enclosed. This covers the average expense of mailing a journal. Domestic journals can be obtained by sending the approximate amount direct to the respective publishers. Thus most of the journals indexed are accessible to the general practitioner, no matter where he may be located.

Albany Medical Annals. M. $2 170 Washington Ave., Albany, N. Y.
American Journal of Anatomy. Bi-m. $5. 36th St. and Woodland Ave., Philadelphia.
American Journal of Diseases of Children. M. $3. American Medical Association, 535 N. Dearborn St., Chicago.
American Journal of Insanity. Q. $5. Johns Hopkins Press, Baltimore.
American Journal of the Medical Sciences. M. $5. Lea & Febiger, 706 Sansom St., Philadelphia.
American Journal of Obstetrics and Diseases of Women and Children. M. $5. Wood & Co., 51 Fifth Ave., New York City.
American Journal of Orthopedic Surgery. Q. $3. P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia.
American Journal of Physiology. M. $5. Johns Hopkins Medical School, Baltimore, Md.
American Journal of Public Health. M. $3. 755 Boylston St., Boston.
American Journal of Roentgenology. M. $5. 32 Adams Ave., West, Detroit.
American Journal of Tropical Diseases and Preventive Medicine. M. $2. P. O. Drawer 602, New Orleans, La.
Annales de gynécologie et d'obstétrique. M. 22 francs. Paris.
Annales de médecine et chirurgie infantiles. Semi-m. 12 francs. Paris.
Annales de la Société médecine et chirurgie de Liége. M. 8 francs.
Annals of Ophthalmology. Q. $4. Mermod-Jaccard Bldg., St. Louis.
Annals of Otology, Rhinology and Laryngology. Q. $4. Mermod-Jaccard Bldg., St. Louis.
Annals of Surgery. M. $5. J. B. Lippincott Co., E. Washington Square, Philadelphia.
Annals of Tropical Medicine and Parasitology. Q. $5. Liverpool.
Archiv für Gynäkologie. Irregular. Price varies. Berlin.
Archiv für Kinderheilkunde. Irregular. 15 marks. Stuttgart.
Archiv für klinische Chirurgie. Irregular. Price varies. Berlin.
Archiv für Verdauungs-Krankheiten. Bi-m. 24 marks. Berlin.
Archives des Sciences Biologiques. Irreg. 9 rubles. Petrograd.
Archives générales de chirurgie. M. 26 francs. Paris.
Archives générales de médecine. M. 18 francs. Paris.
Archives of Diagnosis. Q. $1. 250 W. 73d St., New York.
Archives of Internal Medicine. M. $4. American Medical Association, 535 N. Dearborn St., Chicago.
*Archives internationales de chirurgie. Irregular. 30 francs. Ghent.
*Archives des maladies de l'appareil digestif et de la nutrition. M. 14 francs. Paris.
Archives des maladies du cœur, des vaisseaux et du sang. M. 17 francs. Paris.
*Archives de médecine des enfants. M. 18 francs. Paris.
Archives mensuelles d'obstétrique et de gynécologie. M. 25 francs. Paris.
Archives of Ophthalmology. Bi-m. $5. G. P. Putnam's Sons, 27 W. 23d St., New York.
Archives of Pediatrics. M. $3. E. B. Treat & Co., 241 W. 23d St., New York.
Archives of Roentgen Ray. M. $4.50. London.
Arizona Medical Journal. M. $2. Phoenix, Ariz.
*Beiträge zur Geburtshilfe und Gynaekologie. Irregular. Price varies. Leipsic.
Beiträge zur Klinik der Tuberkulose. Irregular. 16 marks. Würzburg.
*Beiträge zur klinischen Chirurgie. M. Price varies. Tübingen.
Berliner klinische Wochenschrift. W. 24 marks. Berlin.
Boston Medical and Surgical Journal. W. $5. 101 Tremont St., Boston.
Brain: A Journal of Neurology. Irregular. $4. London.
Brazil Medico. W. 20 milreis. Rio de Janeiro.
Bristol Medico-Chirurgical Journal. Bi-m. $3.
British Journal of Children's Diseases. M. $5. London.
British Journal of Surgery. Q. $6.50. William Wood & Company, 51 Fifth Ave., New York.
British Journal of Tuberculosis. Q. $1.25. London.
British Medical Journal. W. $8.50. London.
Bulletin de l'Académie de médecine. W. 20 francs. Paris.
Bulletin of the American Academy of Medicine. Bi-m. $3. 52 N. Fourth St., Easton, Pa.
Bulletin of the Johns Hopkins Hospital. M. $2. Baltimore.
Bulletin of the Lying-in Hospital of the City of New York. Irregular. $1. 23 E. 93d St., New York City.
Bulletin of the Medical and Chirurgical Faculty of Maryland. M. $0.25. 1211 Cathedral St., Baltimore.
Bulletins de la Société de pédiatrie de Paris. M. 10 francs.
California State Journal of Medicine. M. $1. Butler Bldg., San Francisco.
Canadian Medical Association Journal. M. $5. 145 Wellington St., W., Toronto.
Centralblatt für die Grenzgebiete der Medizin und Chirurgie. Irregular. 22 marks. Jena.
Cleveland Medical Journal. M. $2. 2318 Prospect Ave., Cleveland.
Colorado Medicine. M. $2. Metropolitan Bldg., Denver.
Correspondenz-Blatt für schweizer Aerzte. W. 22 francs. Basel.
Delaware State Medical Journal. M. $1. 309 Shipley St., Wilmington, Del.
Deutsche medizinische Wochenschrift. W. 32 marks. Berlin.
*Deutsche Zeitschrift für Chirurgie. M. Price varies. Leipsic.
*Deutsches Archiv für klinische Medizin. Irregular. Price varies. Leipsic.
Dublin Journal of Medical Science. M. $5.
Edinburgh Medical Journal. M. $6.
Gazetta degli ospedali e delle cliniche. Tri-w. 25 francs. Milan.
Glasgow Medical Journal. M. $5.
Grèce médicale. Semi-m. 12 francs. Athens.
Hospitalstidende. W. 27.5 kronen. Copenhagen.
Hygiea. M. $5. Stockholm.
Illinois Medical Journal. M. $2. 3338 Ogden Ave., Chicago.
Indian Medical Gazette. Bi-m. $5. Calcutta.
Jahrbuch für Kinderheilkunde. M. 36 marks. Berlin.
Journal de chirurgie. M. 44 francs. Paris.
Journal de médecine de Bordeaux. W. 15 francs.
Journal d'urologie médicale et chirurgicale. M. 40 francs. Paris.
Journal of Abnormal Psychology. Bi-m. $4. R. G. Badger, 194 Boylston St., Boston.
Journal of the American Medical Association. W. $5. 535 N. Dearborn St., Chicago.
Journal of the Arkansas Medical Society. M. $1. 810 State Bank Bldg., Little Rock, Ark.
Journal of Biological Chemistry. M. $3. 2419 York Road, Baltimore.
Journal of Cutaneous Diseases. M. $5. Rebman Company, 141 W. 36th St., New York.
Journal of Experimental Medicine. M. $5. Rockefeller Institute for Medical Research, 66th St. and Avenue A, New York.
Journal of the Florida Medical Association. M. $1.00. 334 St. James Bldg., Jacksonville, Fla.
Journal of the Indiana State Medical Association. M. $1. 219 W. Wayne St., Fort Wayne, Ind.
Journal of Infectious Diseases. Q. $5. 57th St. and Greenwood Ave., Chicago.
Journal of Iowa State Medical Society. M. $2. Washington, Ia.
Journal of Kansas Medical Society. M. $2. 501 Husted Bldg., Kansas City, Kan.
Journal of Laryngology, Rhinology and Otology. M. $5. London.
Journal of Maine Medical Association. M. $2. Portland, Maine.
Journal of Medical Association of Georgia. M. $1. Harison Bldg., Augusta, Ga.
Journal of Medical Research. M. $4. 240 Longwood Ave., Boston.
Journal of Medical Society of New Jersey. M. $2. 252 Main St., Orange, N. J.
Journal of Michigan State Medical Society. M. $2. 91 Monroe Ave., Grand Rapids, Mich.
Journal of Missouri State Medical Association. M. $2. 3525 Pine St., St. Louis.

W.—Weekly; M.—Monthly; Semi-m.—Semi-monthly; Bi-m.—Bi-monthly; Q.—Quarterly. *Cannot be loaned.

Journal of Nervous and Mental Diseases. M. $5. 64 W. 56th St., New York.
Journal of Obstetrics and Gynecology of the British Empire. M. $6.25. London.
Journal of Oklahoma State Medical Association. M. $2. Muskogee.
Journal of Outdoor Life. M. $1. 289 Fourth Ave., New York.
Journal of Parasitology. Q. $2. Urbana, Ill.
Journal of Pathology and Bacteriology. Q. $5.50. Cambridge, Eng.
Journal of Pharmacology and Experimental Therapeutics. Bi-m. $5. 2419 York Road, Baltimore.
Journal of South Carolina Medical Association. M. $2. Charleston, S. C.
Journal of State Medicine. M. 50 cents. London.
Journal of Tennessee State Medical Association. M. $2. Jackson Bldg., Nashville, Tenn.
Journal of Tropical Medicine and Hygiene. Semi-m. $5. London.
Journal-Lancet. Semi-m. $2. 839 Lumber Exchange, Minneapolis.
Kentucky Medical Journal. Semi-m. $2. Atherton Bldg., Bowling Green, Ky.
Lancet. W. $8. London.
Lancet-Clinic. W. $3. Main near Seventh St., Cincinnati.
Laryngoscope. M. $5. 3858 Westminster Place, St. Louis.
Lyon chirurgical. M. 25 francs.
Lyon médical. W. 20 francs.
Medical Record. W. $5. W. Wood & Co., 51 Fifth Ave., New York.
Medizinische Klinik. W. 32 marks. Berlin.
Military Surgeon. M. $3.50. 535 N. Dearborn St., Chicago.
Mississippi Medical Monthly. M. $1. 506 First National Bank Bldg., Vicksburg, Miss.
Mitteilungen aus den Grenzgebieten der Medizin und Chirurgie. Irregular. 25 marks. Jena.
Mitteilungen aus der medizinischen Fakultät der Kaiserlichen Universität zu Tokyo. Irreg. Price varies. Tokio.
Modern Hospital. M. $3. Metropolitan Bldg., St. Louis.
Monatsschrift für Geburtshülfe und Gynäkologie. M. 42 marks. Berlin.
*Monatsschrift für Kinderheilkunde. M. 20 marks. Leipsic.
Münchener medizinische Wochenschrift. W. 32 marks. Munich.
*Nederlandsch Tijdschrift voor Geneeskunde. W. 10.50 florins. Amsterdam.
New Mexico Medical Journal. M. $2. P. O. 23, Las Cruces, N. M.
New Orleans Medical and Surgical Journal. M. $2. 1551 Canal St., New Orleans.
New York Medical Journal. W. $5. A. R. Elliott Publishing Co., 66 W. Broadway, New York.
New York State Journal of Medicine. M. $1. 17 W. 43d St., New York.
*Nordiskt Mediciniskt Arkiv. Irregular. 30 marks. Stockholm.
Norsk Magazin for Lægevidenskaben. M. $5. Christiania.
Northwest Medicine. M. $2. Cobb Bldg., Seattle, Wash.
Ohio State Medical Journal. M. $2. 207 E. State St., Columbus, Ohio.
Old Dominion Journal of Medicine and Surgery. M. $2. 116 E. Franklin St., Richmond, Va.
Ophthalmic Record. M. $4. 7 W. Madison St., Chicago.
Ophthalmology. Q. $5. 711 Cobb Bldg., Seattle, Wash.
Pediatria. M. 12.50 lire. Naples.
Pediatria. M. 6 rubles. Petrograd.
Pennsylvania Medical Journal. M. $2. Athens, Pa.
Philippine Journal of Science. Irregular. $7. Manila, P. I.
Policlinico. W. 32 lire. Rome.
Practitioner. M. $6.50. London.
Presse médicale. Semi-w. 15 francs. Paris.
Public Health Journal. M. $2. York Publishing Co., Lumsden Bldg., Toronto.
Quarterly Journal of Medicine. $6.50. London.
Revue de chirurgie. M. 33 francs. Paris.
*Revue de gynécologie. M. 30 francs. Paris.
*Revue de médecine. M. 23 francs. Paris.
Revue médicale de la Suisse romande. M. 14 francs. Geneva.
Revue mensuelle de gynécologie, d'obstétrique et de pédiatrie. M. 12 francs. Paris.
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This is an index not only to the reading matter in THE JOURNAL, but also to original articles in the principal medical periodicals of this and other countries. The reading matter appearing in THE JOURNAL is distinguished by the use of **black-faced numerals.**

The letters used to explain in which department the matter indexed appears are as follows: "E," Editorial; "C," Correspondence; "T," Therapeutics; "Ml," Medicolegal; "P" Propaganda for Reform; "ME," Medical Economics; "ab," abstract; the star (*) indicates an "Original Article" in THE JOURNAL.

This is a subject index and one should, therefore, look for the chief word, with the following exceptions: "Deaths" and "Society Proceedings" are indexed under these titles at the end of the letters "D" and "S." Matter pertaining to the Association is indexed under "American Medical Association."

All matter is indexed under the most important word of the heading used in THE JOURNAL, and also under the subject heading. For instance, abscess of the brain will be found under "abscess," as well as under "brain." Such titles as "ocular manifestations, etc." have been indexed under "Eye." Cross references have been liberally used.

The figures in parentheses refer to the paragraph, the number following to the page in THE JOURNAL.

ABDOMEN, gunshot wound of, with rupture of pregnant uterus, *243

This reference is to an original article in THE JOURNAL, as shown both by the star and by the black-faced numerals indicating the page.

ACID, fruit, and blood, 420

This reference, as indicated by the black-faced figures, is also in THE JOURNAL, and on turning to page 420 we find an answer to a question in the Department of Queries and Minor Notes.

HERNIA, diaphragmatic, (125) 1234

In this reference, the (125) indicates that the article is in the Current Literature Department and the fact that the page number is in black-faced type shows that the article is abstracted and discussed in THE JOURNAL. Turning to page 1234 we find (125) refers to an article by S. McGuire in the *Southern Medical Journal*, September.

ACETONEMIA, periodical vomiting with, (87) 813

The fact that in this last reference the page is given in ordinary type indicates that only the title of the article is given. Turning to page 813 we find that the numeral (87) refers to a paper on that subject by G. Hilliger which appeared in *Jahrbuch für Kinderheilkunde*, July.

In the AUTHOR'S INDEX are the names of the authors of articles which have appeared in THE JOURNAL of the American Medical Association and of articles that have been listed from week to week in the Department of Current Medical Literature as having appeared in other journals. The black-faced numerals indicate that the article is in THE JOURNAL, either in full or in abstract. The star (*) preceding the page number, indicates an original article.

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Acad.—Academy,
Am.—American,
A.—Association,
Conf.—Conference,
Cong.—Congress,
Conv.—Convention,
Internat.—International,
M.—Medical, Medicine,
Phar.—Pharmaceutical,
S.—Society,
Surg.—Surgical, Surgery, Surgeons,

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